

# **State of Alaska FY2008 Governor's Operating Budget**

## **Department of Health and Social Services Performance Measures**

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## Department of Health and Social Services

### Mission

To promote and protect the health and well being of Alaskans.

### Core Services

- Provide quality assisted living in a safe home environment.
- Provide an integrated behavioral health system.
- Promote stronger families, safer children.
- Manage health care coverage for Alaskans in need.
- Address juvenile crime by promoting accountability, public safety and skill development.
- Provide self-sufficiency and basic living expenses to Alaskans in need.
- Protect and promote the health of Alaskans.
- Promote independence of Alaska Seniors and people with physical and developmental disabilities.
- Provide quality administrative services in support of the Department's mission.

While the core services serve as the basis for the department's service delivery system the Department has three main guiding principles: self sufficiency for Alaskans, a strong safety net for those who cannot provide for themselves, and local access to care.

End Results	Strategies to Achieve Results
<b>A: Outcome Statement #1: Provide a safe environment for Alaska pioneers and veterans.</b>  <u>Target #1:</u> Injury rate below half the national standard, which is two to six percent. <u>Measure #1:</u> Pioneers Home sentinel event injury rate.	<b>A1: Provide sufficient staffing for safe environment in the homes.</b>
End Results	Strategies to Achieve Results
<b>B: Outcome Statement #2: Improve and enhance the quality of life for Alaskans with serious behavioral health problems.</b>  <u>Target #1:</u> To reduce the number/percentage of kids in out-of-state placement by 50 children annually over the next seven years. <u>Measure #1:</u> Change in number/percentage of children reported in out-of-state care from Medicaid MMIS.  <u>Target #2:</u> To reduce the rate of suicides in Alaska to 10.6 deaths per 100,000 population. <u>Measure #2:</u> Alaska's suicide death rate compared to National rate.  <u>Target #3:</u> Reduce 30 day readmission rate for API to 10%. <u>Measure #3:</u> Rate of API readmissions.	<b>B1: Provide enhancements to prevention and early intervention services.</b>
End Results	Strategies to Achieve Results
<b>C: Outcome Statement #3: Children who come to the</b>	<b>C1: Implementation of new safety assessment model</b>

<p><b>attention of the Office of Children's Services are, first and foremost, protected from abuse or neglect.</b></p> <p><u>Target #1:</u> Decrease the rate of substantiated allegations of child abuse and neglect in Alaska.</p> <p><u>Measure #1:</u> The rate of child abuse and neglect per 1,000 children under the age of 18.</p> <p><u>Target #2:</u> To decrease the rate of repeat maltreatment to meet or exceed the national standard of 6.1 percent.</p> <p><u>Measure #2:</u> Percentage rate of repeat maltreatment.</p> <p><u>Target #3:</u> Decrease the percentage of substantiated maltreatment by out-of-home providers.</p> <p><u>Measure #3:</u> Percentage of children maltreated by an out-of-home provider.</p> <p><u>Target #4:</u> Reduce the rate staff turnover and increase the number of workers providing direct services at any given time.</p> <p><u>Measure #4:</u> Annual employee turnover rate; number of positions available to provide direct services.</p>	<p>to provide front line workers with a better tool to identify safety issues in the home.</p> <p><b>C2: Children placed outside of the home are protected from further abuse and neglect.</b></p> <p><b>C3: Retain an effective and efficient workforce.</b></p>
End Results	Strategies to Achieve Results
<p><b>D: Outcome Statement #4: To provide quality management of health care coverage services to providers and clients.</b></p> <p><u>Target #1:</u> Decrease average response time from receiving a claim to paying a claim.</p> <p><u>Measure #1:</u> Average number of days per annum from receipt of claims to payment of claims.</p> <p><u>Target #2:</u> Increase the percentage of adjudicated claims paid with no provider errors.</p> <p><u>Measure #2:</u> Change in the percentage of adjudicated claims paid with no provider errors.</p> <p><u>Target #3:</u> Reduce the rate of Medicaid payment errors</p> <p><u>Measure #3:</u> Improper payment estimates as provided to Center for Medicare and Medicaid Services</p>	<p><b>D1: Continue to develop new Medicaid Management Information System (MMIS).</b></p>
End Results	Strategies to Achieve Results
<p><b>E: Outcome Statement #5: Improve juvenile offenders' success in the community following completion of services resulting in higher levels of accountability and public safety.</b></p> <p><u>Target #1:</u> Reduce percentage of juveniles who re-offend following release from institutional treatment facilities to less than 40% of the total.</p> <p><u>Measure #1:</u> Percentage change in re-offense rate following release from institutional treatment.</p> <p><u>Target #2:</u> Reduce percentage of juveniles who re-offend following completion of formal court-ordered probation supervision to less than 20% of the total.</p>	<p><b>E1: Implement and review information from research-based assessment tools, and incorporate practices proven to reduce recidivism and criminal behavior among youth.</b></p>

<p><u>Measure #2:</u> Percentage change in re-offense rate following completion of formal court-ordered probation supervision.</p> <p><u>Target #3:</u> Alaska's juvenile crime rate will be reduced by 5% over a two-year period.</p> <p><u>Measure #3:</u> Percentage change of Alaska juvenile crime rate compared to the rate one and two years earlier.</p> <p><u>Target #4:</u> Divert at least 60% of youth referred to the Division away from formal court processes as appropriate given their risks, needs, and the seriousness of their offenses.</p> <p><u>Measure #4:</u> The percentage of referrals that are managed through informal processes.</p>	
End Results	Strategies to Achieve Results
<p><b>F: Outcome Statement #6: Low income families and individuals become economically self-sufficient.</b></p> <p><u>Target #1:</u> Increase self-sufficient individuals and families by 10% annually.</p> <p><u>Measure #1:</u> Rate of change in self-sufficient families.</p>	<p><b>F1: Use TANF high performance bonus funds for families approaching 60-month time limit.</b></p>
End Results	Strategies to Achieve Results
<p><b>G: Outcome Statement #7: Healthy people in healthy communities</b></p> <p><u>Target #1:</u> 80% of all 2 year olds are fully immunized</p> <p><u>Measure #1:</u> % of all Alaskan 2 year olds fully immunized</p> <p><u>Target #2:</u> Reduce post-neonatal death rate to 2.7 per 1,000 live births by 2010</p> <p><u>Measure #2:</u> Three year average post-neonatal mortality rate (Post-neonatal is defined as 28 days to 1 year)</p> <p><u>Target #3:</u> Decrease diabetes in Alaskans</p> <p><u>Measure #3:</u> Prevalence of Diabetes among Adults (18+) in Alaska based upon three-year averages</p> <p><u>Target #4:</u> Decrease Alaska's adult obesity rate to less than 18%</p> <p><u>Measure #4:</u> Obesity rate of Alaskans</p>	<p><b>G1: Strengthen public health in strategic areas.</b></p>
End Results	Strategies to Achieve Results
<p><b>H: Outcome Statement #8: Senior and physically and/or developmentally disabled Alaskans live independently as long as possible.</b></p> <p><u>Target #1:</u> Increase the number of DD waiver recipients receiving Supported Employment Services.</p> <p><u>Measure #1:</u> % change of beneficiaries receiving supported employment services under Developmental Disabilities Waiver.</p>	<p><b>H1: Promote independent living and provide preadmission screening to nursing homes.</b></p>

End Results	Strategies to Achieve Results
<b>I: Outcome Statement #9: The efficient and effective delivery of administrative services.</b>  <u>Target #1:</u> Increase by 5% the percentage of customers that report Finance and Management Services (FMS) is meeting their needs. <u>Measure #1:</u> Percentage of customer service internal survey respondents that report FMS is meeting their needs.  <u>Target #2:</u> Reduce the average response time for complaints/inquiries to 14 days. <u>Measure #2:</u> Department Inquiry/Complaint "HSS Track" log response times.  <u>Target #3:</u> Reduce by 5% per year processing time for key indicators. <u>Measure #3:</u> Track number of days it takes to process: Purchase Requisitions; Operating Grant Awards; Processing Time for Payments; Capital Grant Awards; and Legislative inquiries.	<b>I1: Implement results of Business Process Review.</b>

### FY2008 Resources Allocated to Achieve Results

**FY2008 Department Budget: \$2,160,336,100**

**Personnel:**

Full time	3,314
Part time	107
<b>Total</b>	<b>3,421</b>

### Performance Measure Detail

#### A: Result - Outcome Statement #1: Provide a safe environment for Alaska pioneers and veterans.

**Target #1:** Injury rate below half the national standard, which is two to six percent.

**Measure #1:** Pioneers Home sentinel event injury rate.

#### Alaska Pioneer Home Sentinel Event Injury Rate

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	2.9%	0.7%	0%	0.37%	.99%
2003	1.1%	.04%	1.79%	1.5%	1.1%
2004	1.96%	0.126%	0.97%	1.47%	1.45%
2005	2.6%	2.4%	1.5%	2.3%	2.2%
2006	0.6%	2.7%	1.3%	1.1%	1.43%
2007	4.0%	0	0	0	0
		0%	0%	0%	0%

*The Sentinel Event injury rate reports the percentage of falls that resulted in a major injury. The rate is calculated by dividing the number of Sentinel injuries to Pioneer Homes residents by the total number of falls reported for the same quarter.*

**Analysis of results and challenges:** The elderly, who represent 12 percent of the population, account for 75 percent of deaths from falls.

The average age in the Pioneer Homes is 84.5. This puts the residents in the highest risk category, and they are more likely to suffer a serious injury from a fall, and experience significant morbidity thereafter.

The Pioneer Homes will respond to serious injuries with root cause analysis investigations and corrective action plans to address underlying causes.

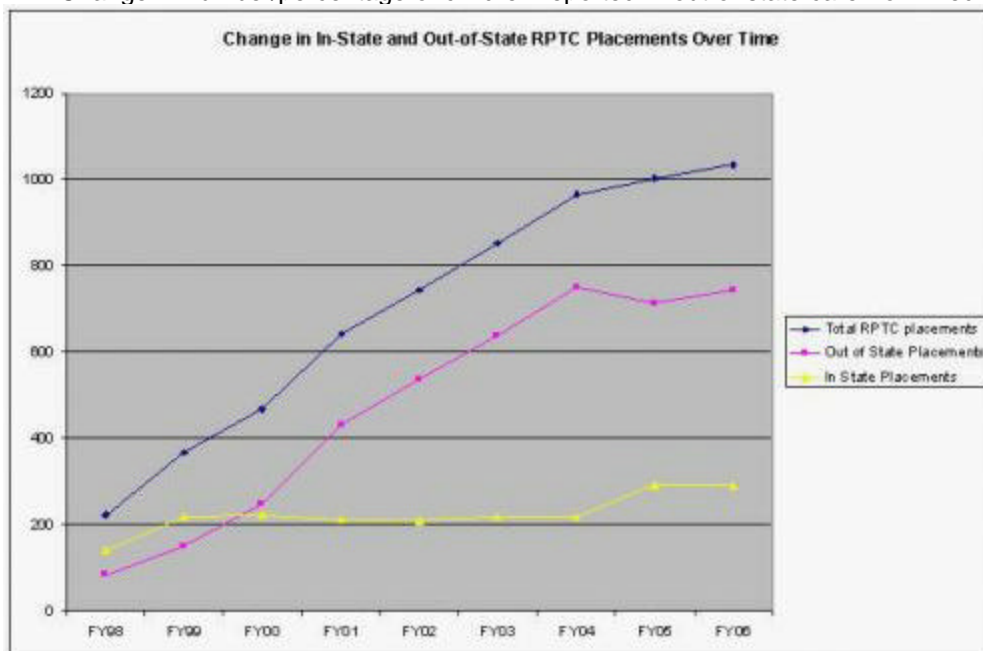
Despite remarkable advances in almost every field of medicine, the age-old problem of health-care errors continues to haunt health care professionals. When such errors lead to "sentinel events," those with serious and undesirable occurrences, the problem is even more disturbing. The event is called "sentinel" because it sends a signal or warning that requires immediate attention. One in three people age 65 and older, and 50 percent of those 80 and older fall each year. The National Safety Council lists falls in older adults as five times more likely to lead to hospitalization than other injuries. One estimate suggests that direct medical costs for fall-related injuries will rise to \$32.4 billion by 2020. Falls can have devastating outcomes, including decreased mobility, function, independence, and in some cases, death.

### A1: Strategy - Provide sufficient staffing for safe environment in the homes.

### B: Result - Outcome Statement #2: Improve and enhance the quality of life for Alaskans with serious behavioral health problems.

**Target #1:** To reduce the number/percentage of kids in out-of-state placement by 50 children annually over the next seven years.

**Measure #1:** Change in number/percentage of children reported in out-of-state care from Medicaid MMIS.



Source: DBH Policy and planning using MMIS-JUCE data, unduplicated count of RPTC beneficiaries.

**Analysis of results and challenges:** For the past eight years there has been a steady increase in the number of children receiving out-of-state Residential Psychiatric Treatment Center (RPTC) services. Between SFY 1998 and 2004, the unduplicated number of youth with Serious Emotional Disorders (SED) receiving out-of-state RPTC care has steadily increased – on average 46.7% per year. The RPTC population as a whole has also showed steady increase from SFY 98-04, an average annual increase of 24.8%.

The Bring the Kids Home Project was initiated during SFY 2004. Positive changes are already apparent. Between SFY 2004 and 2005 there was a 5.1% reduction in the number of children receiving out-of-state RPTC care, from 749 to 711. However, between SFY 2005 and 2006, there was again an increase in out-of-state

placement, of 5%, from 711 to 743. In SFY 2006, there has also been a 3% increase in total RPTC placements. The historical average increase of 46.7% for out-of-state placements has been effectively challenged with the efforts to enhance "step-down" activities, that is, programs for children that are less intensive, less restrictive, and closer to home, than out-of-state residential programs.

Alaska Statute 47.07.032 requires that the department may not grant assistance for out-of-state inpatient psychiatric care if the services are available in the state. To that end, the Department has developed and implemented "diversion" activities, including aggressive case management services that discharge and return children to less restrictive levels of care; utilization review staff implementing gate-keeping protocols with a "level of care" instrument that insures appropriate placements; and collaboration with community-based providers to augment services at the least restrictive level within a client's home community. There have also been multiple capital projects initiated to increase the number of beds in-state, some of which have become available in SFY 07. As more new beds and other programs become available, it is anticipated that there will be further impact on the rate of out-of-state placements. This project is a collaboration of the Division of Behavioral Health, Division of Juvenile Justice and Office of Children's Services, in partnership with the Mental Health Trust Authority.

**Target #2:** To reduce the rate of suicides in Alaska to 10.6 deaths per 100,000 population.

**Measure #2:** Alaska's suicide death rate compared to National rate.

<b>Suicide by Age Group 1998-2005</b>		
<b>Age Group</b>	<b>Deaths</b>	<b>Rate</b>
05-14	17	1.9
15-24	275	37.7
25-34	188	26.7
35-44	201	22.7
45-54	182	22.9
55-64	76	18.6
65-74	32	17.0
75-84	21	23.1
85+	6	25.4
*Rates are age-specific rates per 100,000 population.		
<b>Suicides by Region 1998-2005</b>		
<b>Region</b>	<b>Deaths</b>	<b>Rate</b>
Anchorage/Mat-Su	412	16.2
Fairbanks/SE Fairbanks	121	18.1
Gulf Coast	108	19.1
Northern/Interior	158	61.2
Southeast	71	12.4
Southwest	128	40.9
*Rates are age-adjusted rates per 100,000 standard population		

**Rate of Suicides 1998-2005**

Year	Alaska Rate	Lives Lost	US Rate
1998	22.7	131	11.1
1999	17.2	95	10.5
2000	21.1	135	10.4
2001	16.5	103	10.7
2002	20.9	131	10.9
2003	20.6	124	10.8
2004	23.5	155	10.7
2005	18.8	122	N/A

\*Rate is number per 100,000 standard population and accounts for differences in population distribution.

\*The US rate for 2005 will not be available until approximately April 2007.

**Analysis of results and challenges:** Alaska averages 125 suicides per year and has a suicide rate double the National Suicide rate. The Healthy Alaskan 2010 target is to reduce Alaska's rate to 10.6 deaths per 100,000 populations. The suicide rate for Alaska in 2005 shows a slight decline, however is still at 18.8, still much higher than the target. This measure reflects a system-wide problem that takes coordination between state agencies, community providers, school districts and faith based organizations.

Work continues to better understand the underlying causes of suicide of Alaskans. The Statewide Suicide Prevention Council partners with the Department of Health and Social Services, Division of Behavioral Health to provide training on the Statewide Suicide Prevention Plan and assessing community readiness for decreasing suicide and non-lethal suicidal behaviors. The Division of Behavioral Health has done the following: required all community-based suicide grantees align their suicide prevention efforts with the Suicide Prevention plan; conducted a presentation on community-based planning implementing effective strategies aligned with the statewide plan; and coordinated with Native health corporations, police, chaplains, and other groups to assist in suicide prevention or coping program design.

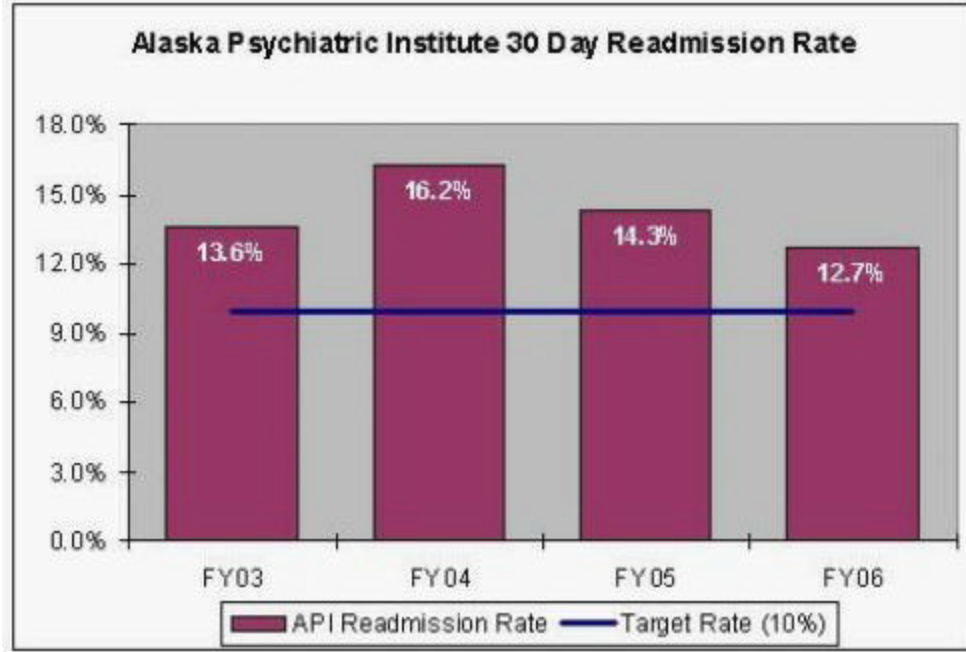
An interim report of the Suicide Follow-Back Study shows the following system-wide factors, based on a limited number of interviews, of those related to, or close to those who had died by suicide:

- 54% had quit working during the preceding year;
- 47% were seeing a therapist at the time of their death;
- 59% had current prescriptions for mental health problems;
- 65% experienced an event that caused a great deal of shame (such as sexual abuse, child porn, an arrest, etc.);
- 61% had problems with law enforcement;
- 20% were abused as children – 80% by their father;
- 50% were seen by a doctor in the last six months;
- 46% had symptoms of post traumatic stress disorder (PTSD);
- 62% were active smokers;
- 33% had prior suicide attempts; and
- 20% had recent exposure to suicide of a loved one.

As the tables above show, the rate of suicides and number of deaths is higher in the Northern/Interior and Southwest regions of Alaska and is more predominant in the 15-24 age group. The overall age span with highest suicide incidents is 15-24.

**Target #3:** Reduce 30 day readmission rate for API to 10%.

**Measure #3:** Rate of API readmissions.



**Analysis of results and challenges:** This measure tracks the percent of admissions to the facility that occurred within 30 days of a previous discharge of the same client from the same facility. For example, a rate of 8.0 means that 8% of all admissions were readmissions. This measure not only is an indication of successful outcomes for API, but also of the mental health community system. The ultimate goal is to have Alaska's rate fall below 10%.

According to data for FY 06, API and the 'system' continue to demonstrate unsatisfactory outcomes. API relocated to a new hospital in July 2005. The success of a 'downsized' state psychiatric hospital was predicated on increased funding for community providers and establishing 18 designated evaluation and treatment beds in Anchorage. These initiatives did not receive planning or funding. As a result, API comes under increasing pressure to shorten length of stays for acutely ill psychiatric patients who ultimately return to the hospital due to lack of adequate supportive housing and treatment options.

**B1: Strategy - Provide enhancements to prevention and early intervention services.**

**C: Result - Outcome Statement #3: Children who come to the attention of the Office of Children's Services are, first and foremost, protected from abuse or neglect.**

**Target #1:** Decrease the rate of substantiated allegations of child abuse and neglect in Alaska.

**Measure #1:** The rate of child abuse and neglect per 1,000 children under the age of 18.

**Rate of Child Abuse & Neglect Per 1,000 Children Under Age 18 in Alaska**

Fiscal Year	Rate Per 1,000	National Rate
FY 2001	32.2	0
FY 2002	27.6	0
FY 2003	23.0	0
FY 2004	22.3	0
FY 2005	N/A	0
FY 2006	16.0****	11.9

\*\*\*\* The Office of Children's Services is now through its second year using the new case management system - Online Resources for the

*Children of Alaska (ORCA). With the implementation of ORCA, new methods of measurement in compliance with federal standards have been used. While the underlying federal methodology for computing measures remains the same, measures computed from these two different systems should not be considered comparable. As a result, FY 2006 data is not comparable to FY 2001 through FY 2004.*

*Due to data instability resulting from the conversion of the old data system to ORCA, the FY05 information is not reliable and not available for analysis.*

*The FY 2006 measures represent an unduplicated number of children with substantiated abuse or neglect per 1,000 children in the population. The population equals the number of children under the age of 18 years as of July 1, 2005, as estimated by the Department of Labor. Data reported prior to FY 2006 can be duplicative.*

*Source: Target of 11.9 - United States Department of Health and Human Services Administration for Children and Families, Child Maltreatment, 2004.*

**Analysis of results and challenges:** The Office of Children's Services goal is to protect children from abuse and neglect. Measuring the success of children's services agencies can be done, in part, through the number of substantiated child protective services reports received per 1,000 children under the age of 18 in the state.

The Department of Labor reports 194,595 children under the age of 18 in Alaska as of July 1, 2005. The Office of Children's Services investigated 10,195 child protection reports of abuse and/or neglect and substantiated abuse and/or neglect for 3,118 children in FY 2006, or 16 per 1,000 children in the state.

In FY 2004, national levels of substantiated abuse and neglect per 1,000 children was calculated by Child Trends Databank at 11.9 and averaged 12.2 over five years. This places Alaska's victim rate at 31% higher than the national average.

While the Office of Children's Services met all of its goals as set out in the Federal Performance Improvement Plan by August 2006, outcomes affecting children and their families still need to improve. The division has embarked on several new approaches to address this issue regarding the children in our state, including a new Safety Assessment model.

When the Office of Children's Services determined that its safety assessment model was ineffective at assessing the difference between safety threats and risk factors, a new safety model was introduced and is being implemented. FY 2006 one time only training money was used to train every front line staff, supervisor, manager, key central office staff and several interested tribal partners. The new model and subsequent training focused on requiring workers to take more time to do a throughout assessment each time a new investigation is assigned.

One of the fundamental differences in the new model requires workers to do an assessment of the entire family and their overall functioning and to look beyond whether the abuse or neglect is substantiated or not substantiated. In the past, workers focused just on the maltreatment itself and did not address other issues going on in the home. This resulted in missed opportunities to engage families in remedial services to avoid subsequent abuse and neglect to the child. Further, the new model helps workers to understand the essential differences in whether the child is unsafe or at risk. Unsafe determinations require OCS intervention, while risk factors may necessitate a referral to community resources. This will result in better identification of families that must be served by the child protective services system versus those that can be served by other resources.

OCS staff, community providers and tribal partners all agree this is a better way to work with families; however, workloads make the new process very difficult to achieve given the time requirement to complete a thorough assessment.

**Target #2:** To decrease the rate of repeat maltreatment to meet or exceed the national standard of 6.1 percent.

**Measure #2:** Percentage rate of repeat maltreatment.

Year	YTD Total	Target
2000	23.6%	0
2001	25.4%	0
2002	22.6%	0
2003	17.6%	0
2004	17.3%	0
2005	10.6%****	6.1%

Data Source: National Child Abuse and Neglect Data System and Alaska's Online Resources for the Children of Alaska (ORCA).

FFY 2006 data will be available in November, 2006.

\*\*\*\*Introduction of Online Resource for the Children of Alaska (ORCA). With the transition from the old case management system (PROBER) to the new system (ORCA), data definitions, policies, and collection procedures have been changed to conform with federal requirements. While the underlying federal methodology for computing measures remains the same, measures computed from these two different systems should not be considered comparable.

Data for this measure submitted to the federal government in FFY 2005 in compliance with the National Child Abuse and Neglect Data System requirements indicated an 8% repeat maltreatment rate. Further research, data clean-up efforts, and a separate analysis cross-checking and linking different data sources indicated the 8% was under-reported. The division has incorporated new findings into this measure.

**Analysis of results and challenges:** The federal guideline for repeat maltreatment includes all children who are victims of substantiated child abuse and/or neglect twice during a six month period. Because Alaska's rate of repeat maltreatment has been so high, a protocol was developed to more closely examine past investigations resulting in a substantiated finding of abuse or neglect. If there have been past substantiated investigations, the OCS worker will review the previous record to ascertain whether the newly reported allegations are against the same child by the same maltreater. If so, the worker and his/her supervisor will devise a strategy for intervention for the current investigation acknowledging that there may be a pattern of abuse that needs to be recognized. The supervisor will closely monitor the progress of the investigation and ensure the appropriate actions are taken to protect the child from further abuse.

It is expected that OCS will begin to see improvements in the number of repeat maltreatment cases not only due to this new business practice, but a positive effect is expected due to increased efforts in prevention, i.e., increased early intervention/infant learning program screenings for young children with substantiated protective services reports.

The chart above shows an adjusted rate of improvement because of the transition between the old case management system (PROBER) and the new (ORCA). FFY 2005 data has been adjusted after further work was completed. The OCS will now focus on meeting or exceeding national standards.

**Target #3:** Decrease the percentage of substantiated maltreatment by out-of-home providers.

**Measure #3:** Percentage of children maltreated by an out-of-home provider.

#### Percentage of Children Maltreated by an Out-of-Home Care Provider

Fiscal Year	Quarter 1	National Rate
FFY 2000	1.91%*	0
FFY 2001	2.00%*	0
FFY 2002	2.09%*	0
FFY 2003	1.35%	0
FFY 2004	1.20%	0
FFY 2005	1.10%****	.57%

\* Data is based on a calendar year. Federal mandates changed to the federal fiscal year in 2003.

\*\*\*\*Introduction of ORCA. With the transition from the old case management system (PROBER) to the new (ORCA) system, data definitions, policies, and collection procedures have been changed to conform with federal requirements. While the underlying federal

methodology for computing measures remains the same, measures computed from these two different systems should not be considered comparable.

FFY 2006 data from the National Child Abuse and Neglect Data System (NCANDS) and federal Adoption and Foster Care Analysis and Reporting System (AFCARS) will be available in November, 2006.

Source: Target of .57% - United States Department of Health and Human Services Administration for Children and Families, Child Maltreatment, 2004.

**Analysis of results and challenges:** Recognition that the rate of abuse of children placed outside of the home by a care provider is unacceptable lead the OCS to launch a new process to assess prospective foster and adoptive parents ("resource families") before licensure and placement of children in the home. The new process was piloted in Anchorage last year and this year expanded to other regions and more rural locations. The Resource Family Assessment is far more comprehensive than the previous licensure process and continued evaluation and changes are being made to the program as determined necessary. One of the primary issues is the amount of time needed to complete the new assessment. While most all agree it is a better way to look at potential foster or adoptive families, it requires much more from already strained resources.

**Target #4:** Reduce the rate staff turnover and increase the number of workers providing direct services at any given time.

**Measure #4:** Annual employee turnover rate; number of positions available to provide direct services.

#### Office of Children's Services Vacancy /Turnover Rates & the Number of Positions Filled

Fiscal Year	Vacancy Rate	Turnover Rate	Avg. # Positions Filled	Target
FY 2001	N/A	24.84%	N/A	0
FY 2002	N/A	24.21%	N/A	0
FY 2003	N/A	23.55%	N/A	0
FY 2004	7.59%	20.27%	275	0
FY 2005	9.48%	20.97%	307	0
FY 2006	9.30%	28.37%	315	20%

Vacancy Rate and number of positions filled methodology is based on a calendar year average. FY 2006 turnover rate is year-to-date as of September, 2006. Turnover rates exclude lateral transfers and promotions within OCS. As of September, 2006 there were 31 (10% of average number of positions filled) lateral transfers and 23 promotions (7% of average number of positions filled).

Includes direct service (front line) workers only.

**Analysis of results and challenges:** The Office of Children's Services contracted with Hornby Zeller Associates, Inc. last year to complete a workload study to provide OCS leadership with a way to evaluate whether front line staff had sufficient time to meet the basic requirements of their jobs to protect children and serve families. Workload is defined as the amount of time needed to complete the tasks necessary as opposed to caseloads that only count the numbers of families served with no regard to the differences in the amount of time to properly handle assigned cases. The final report with the results and recommendations was received in May 2006. The contractor concluded that a plan needed to be developed to fill existing vacancies and monitor caseloads over time before engaging in wide scale changes to personnel that would include transferring positions from over-staffed offices to under-staffed offices. While staffing patterns over time need to continue to be monitored and assessed, the contractor did conclude in order to meet the workload of the state, OCS needs an additional 19 positions to handle the state's entire caseload appropriately as mandated by state and federal policy guidelines.

In addition, the work load study revealed that front line workers and supervisors spend on average 12.4% of their time on administrative tasks. With the addition of the new front line staff as authorized in FY 2005 and FY 2006 but no administrative staff added, more administrative tasks have fallen to workers. The OCS will request additional administrative support when allowed to do so.

Lastly, a comprehensive plan to address retention and recruitment of front line staff is currently in development. The OCS understands that worker turnover continues to be high and of great concern and previous strategies have not changed that fact; therefore, greater emphasis and planning is necessary.

This measure has been enhanced by adding vacancy rates and the average number of direct service positions filled. Turnover rates, while extremely high and disruptive, do not provide a complete picture. OCS added

vacancy rates as a measure of positions vacant at any given time through a year and filled positions to show that while turnover and vacancy rates remain high, progress in the number of available workers at any time has improved.

**C1: Strategy - Implementation of new safety assessment model to provide front line workers with a better tool to identify safety issues in the home.**

**C2: Strategy - Children placed outside of the home are protected from further abuse and neglect.**

**C3: Strategy - Retain an effective and efficient workforce.**

**D: Result - Outcome Statement #4: To provide quality management of health care coverage services to providers and clients.**

**Target #1:** Decrease average response time from receiving a claim to paying a claim.

**Measure #1:** Average number of days per annum from receipt of claims to payment of claims.

**Operation Performance Summary-Annual Average Days /Entry Date to Claims Paid Date**

Fiscal Year	Claims	Avg Days	Days Changed
FY 2000	3,720,254	10	0
FY 2001	4,409,121	12	2
FY 2002	4,959,864	12	0
FY 2003	5,615,072	10	-2
FY 2004	6,690,344	10	0
FY 2005	7,903,523	13	3
FY 2006	7,721,709	12	-1
FY 2007	1,793,488	22	10

*Note: Between FY02 and FY03 reports were based on six months of data. Since SFY04 reports are based on annual data. Source: MARS MR-0-08-T. No national average available.*

**Analysis of results and challenges:** Average days to pay between first quarter State Fiscal Year (SFY) 2006 and first quarter SFY 2007 increased from 16 days in 2006 to 22 days in 2007.

Three new initiatives, two in the second half of SFY 2006 and the other in first quarter 2007 may provide explanations for the increase of average days. The Personal Care Program instituted a prior authorization process during the third quarter 2006. As part of this new initiative, claims became subject to prior authorization editing. Additionally, regulatory changes for certain Durable Medical Equipment (DME) high-volume supplies occurred during the second half of SFY 2006. This resulted in additional claims pending for evaluation and pricing. Lastly, during the first quarter 2007, several new home and community-based waiver program edits were initiated.

Adding to the hindrance, the Department of Health and Social Services' (HSS) contractor experienced a data entry backlog as they converted from outsourced data entry services to in-house data entry. As training is completed and staff becomes more proficient, holdups are improving for the second quarter of SFY 2007.

All of the above would have had impact on processing time.

**Target #2:** Increase the percentage of adjudicated claims paid with no provider errors.

**Measure #2:** Change in the percentage of adjudicated claims paid with no provider errors.

**Error Distribution Analysis-Change in the percentage of adjudicated claims paid with no provider errors**

Fiscal Year	Claims Pd	% No Errors	% Change
FY 2000	3,076,978	72%	0
FY 2001	3,670,331	73%	1%
FY 2002	4,202,677	74%	1%
FY 2003	4,776,730	73%	-1%
FY 2004	5,106,692	76%	3%
FY 2005	6,150,027	72%	-4%
FY 2006	6,082,318	74%	2%
FY 2007	1,363,276	72%	-2%

**Chart Notes**

1. Between FY01 and FY03 reports were based on six months of data. Since FY04 reports are based on annual data.
2. This measure was updated annually through SFY 2005; beginning with SFY 2006, it is being updated quarterly.
3. Source: MARS MR-0-11-T.
4. FY07 numbers are for the first quarter of FY07.

**Analysis of results and challenges:** Error distribution analysis is designed to capture the percentage of adjudicated claims paid with no provider errors. To ensure correct claim submission from providers, Health Care Services works with providers to resolve problem areas and to get claims paid. First Health, Medicaid's fiscal agent, provides training to providers on billing procedures, publishes billing manuals, and has a website for providers with information tailored to each provider type.

During SFY2006, the Department of Health and Social Services (HSS) had two major initiatives that impacted pharmacy: Pharmacy Cost Avoidance and Medicare Part D.

Prior to Pharmacy Cost Avoidance, HSS, as the State Medicaid Agency, paid the pharmacy claims for recipients who had insurance primary to Medicaid and then attempted to recover the costs from liable third parties. The Pharmacy Cost Avoidance initiative changed this practice and therefore the number of claims denied because of other insurance coverage is significant.

Additionally, Medicare Part D required HSS to deny pharmacy claims for Medicare-covered drugs for those recipients of both Medicaid and Medicare. Previously, Medicaid paid for this same population. This results in a significant denial of claims.

These major changes to the Pharmacy program were surely noteworthy enough to result in the decrease of claims paid, and as such, claims paid without error.

**Target #3:** Reduce the rate of Medicaid payment errors

**Measure #3:** Improper payment estimates as provided to Center for Medicare and Medicaid Services

**Analysis of results and challenges:** The Improper Payments Information Act of 2002 (Public Law 107-300) requires Federal agencies to annually review and identify those programs and activities that may be susceptible to significant erroneous payments, estimate the amount of improper payments and report those estimates to the Congress, and if necessary, submit a report on actions the agency is taking to reduce erroneous payments. The effect of this rule is that States are now to be required to produce improper payment estimates for their Medicaid and SCHIP programs and to identify existing and emerging vulnerabilities.

The PERM program commenced nationally on July 1, 2005 with Phase I and one-third of the states participated. Alaska is a year 3 state and will be required to participate during calendar year 2007. There will be an impact on the resources in each Division managing Medicaid Services to assist the PERM staff with access to policies, procedures and data. Division staff may be called upon to assist in the interpretation of medical records pertaining to claims associated with services that Division manages. The PERM process includes expectations for corrective actions. Divisions will need resources to implement corrective actions resulting from PERM findings.

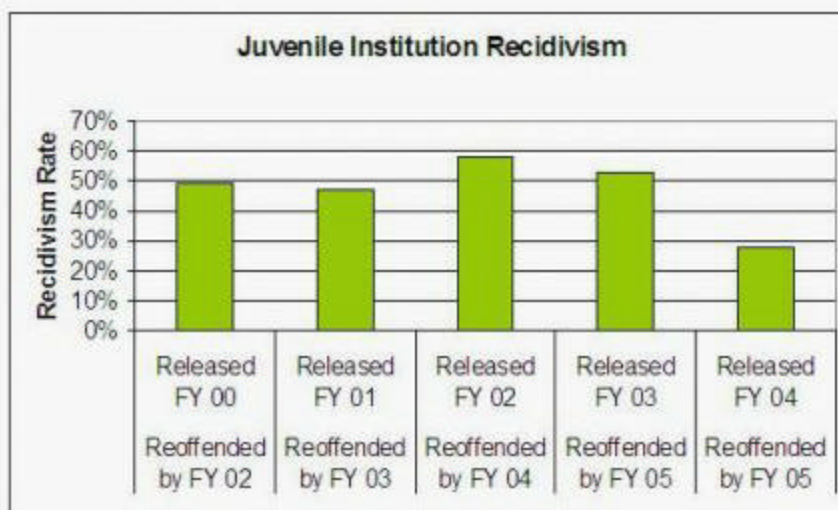
**D1: Strategy - Continue to develop new Medicaid Management Information System (MMIS).**
**E: Result - Outcome Statement #5: Improve juvenile offenders' success in the community following completion of services resulting in higher levels of accountability and public safety.**

**Target #1:** Reduce percentage of juveniles who re-offend following release from institutional treatment facilities to less than 40% of the total.

**Measure #1:** Percentage change in re-offense rate following release from institutional treatment.

Facility	Number released in FY 04	Number of reoffenders 12 months after release	Percentage of offenders who reoffended
Bethel Youth Facility	10	3	30%
Fairbanks Youth Facility	22	9	41%
Johnson Youth Center	18	8	44%
McLaughlin Youth Center	94	20	21%
<b>Total</b>	<b>144</b>	<b>40</b>	<b>28%</b>

Race	Number released in FY 04	Number of reoffenders 12 months after release	Percentage of offenders who reoffended
Caucasian	59	15	25%
African American	9	6	67%
Native Alaskan/American Indian	57	12	21%
Asian	2	2	100%
Pacific Islander	1	1	100%
Multiple Races	15	4	27%
Other	1	0	0%
<b>Total</b>	<b>144</b>	<b>40</b>	<b>28%</b>



**Analysis of results and challenges:** This measure examines recidivism only for youth who have been committed to and released from one of the Division's four juvenile treatment facilities. These youth typically have the most intensive needs and are the state's more chronic and serious juvenile offenders compared with youth who only receive probation supervision. Recidivism rates for these two populations are considered separately because of the distinctively different levels of risk and need presented, and the different types of interventions and programming received.

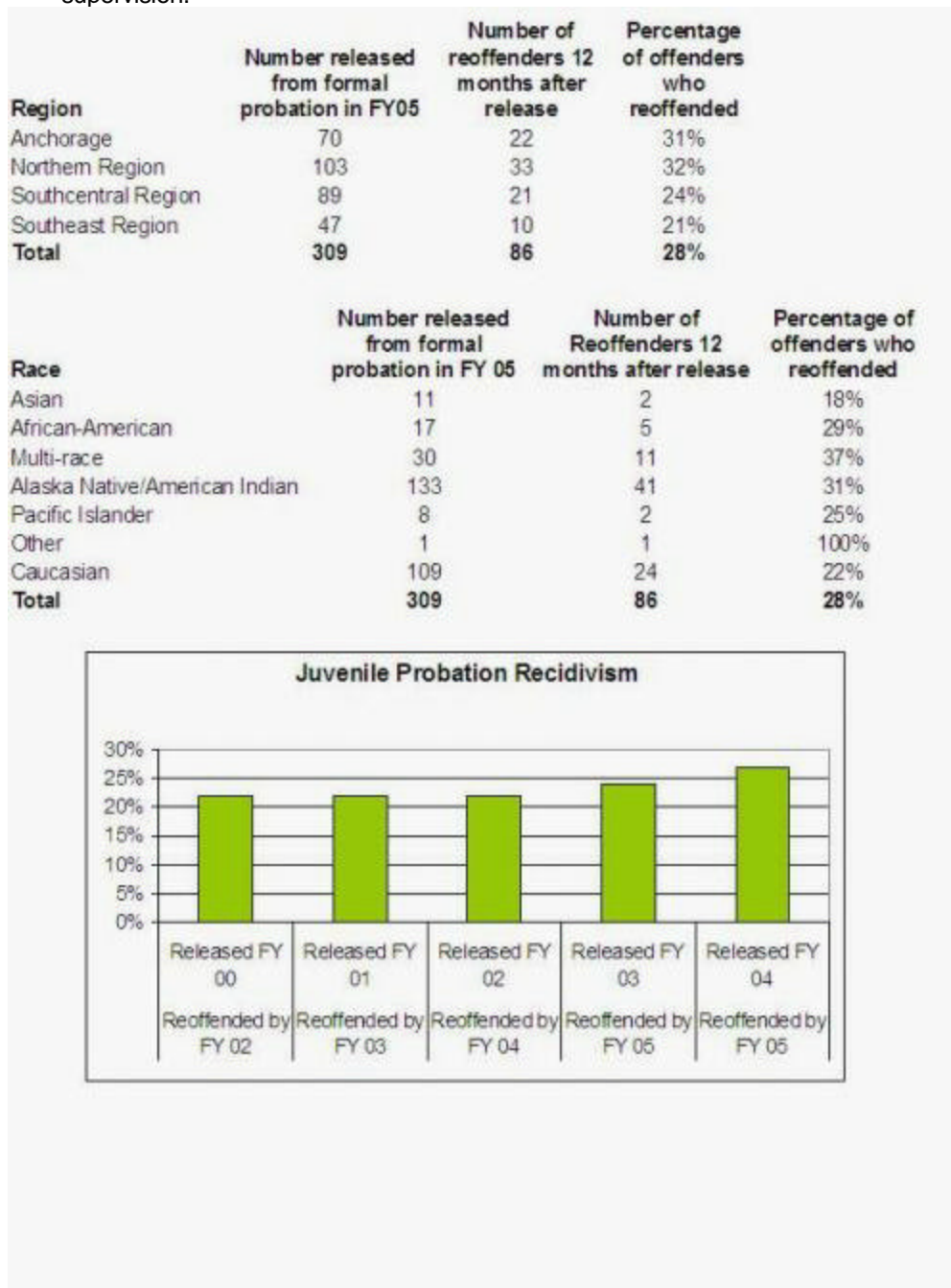
The major reason for the demonstrated drop in recidivism among this group was the change this fiscal year from surveying recidivism among juveniles in a 24-month window to 12 months. This change was made to better align Alaska's reporting of recidivism with the national norm of reporting recidivism on a 12-month basis. (Sixteen of the 32 states that track recidivism do so on a 12-month basis.) Among those states that measure recidivism based on a 12-month follow-up period, and that consider offenses "recidivism" if they result in a conviction or adjudication in the juvenile or adult systems (8 states, including Alaska), the average recidivism rate was 33%. Alaska, at a 28% rate, compares favorably with this average. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.)

Reoffenses, like the original offenses that brought the juveniles to the Division's attention, may be felonies, misdemeanors, drug offenses, weapons crimes, crimes against persons, crimes against property, and other state crimes. Often these crimes are committed while the juvenile is under the influence of alcohol or other drugs, or in the context of domestic violence. The Division has adopted a new risk and needs assessment tool to better work with juveniles to address the root causes of their law-breaking behavior, and will continue to review institutional treatment components and research-based practices as it seeks to improve its outcomes for youths leaving institutions.

Note: Reoffenses by juveniles released from Alaska's treatment institutions are determined through analysis of entries in the Division of Juvenile Justice's database and the Alaska Public Safety Information Network. Reoffenses are defined as: any offenses resulting in a new juvenile institutional order, a new juvenile adjudication, or an adult conviction. Adjudications and convictions for motor vehicle, Fish & Game, non-habitual Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudication and convictions received outside Alaska are excluded from analysis. To be counted as recidivists, youth must have committed an offense within 12 months of their release date, and the offense must have resulted in an adult conviction, a new juvenile adjudication, or a new juvenile institutional order for a probation violation.

**Target #2:** Reduce percentage of juveniles who re-offend following completion of formal court-ordered probation supervision to less than 20% of the total.

**Measure #2:** Percentage change in re-offense rate following completion of formal court-ordered probation supervision.



**Analysis of results and challenges:** This measure examines reoffense rates for juveniles who received probation supervision while either remaining at home or in a nonsecure custodial placement. These youths typically have committed less serious offenses and have demonstrated less chronic criminal behavior than youth who have been institutionalized (and whose recidivism rate is discussed in measure #1). Recidivism rates for these two populations are considered separately because of the distinctively different levels of risk and need presented, and the different types of interventions and programming received.

As with the institutional population performance measure, this measure was changed this year such that re-

offenses were counted as recidivism if they occurred within 12 months, rather than 24 months, from the time offenders were released from formal probation. This measure also was changed to better correlate with the institutional recidivism measure (as well as national recidivism statistics) in that an offense needed to result in a new adjudication in the juvenile system or a conviction in the adult system to be counted as a reoffense (previously, only referrals to the juvenile system were counted as reoffenses). The increase in recidivism among the population of youth released from formal probation in FY 04 is primarily due to the inclusion of offenses occurring within the adult system. Inclusion of adult offenses is a more accurate measure of the activity of offenders once they are released from juvenile probation.

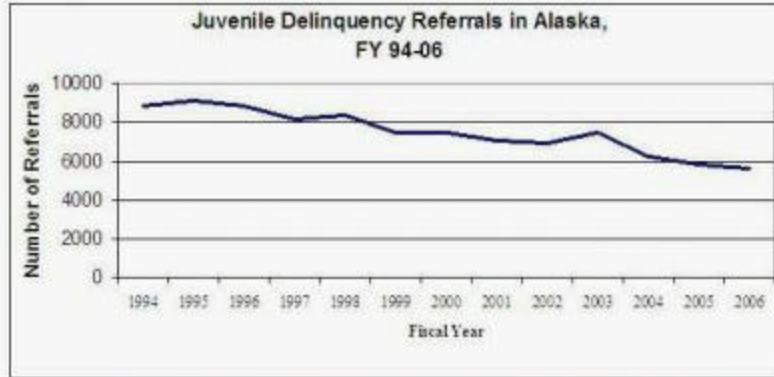
Sixteen of the 32 states that track recidivism do so on a 12-month basis. Among those states that measure recidivism based on a 12-month follow-up period and that consider offenses "recidivism" if they result in a conviction or adjudication in the juvenile or adult systems (8 states, including Alaska), the average recidivism rate was 33%. Alaska, at a 28% rate, compares favorably with this average. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.)

Reoffenses, like the original offenses that brought the juveniles to the Division's attention, may be felonies, misdemeanors, drug offenses, weapons crimes, crimes against persons, crimes against property, and other state crimes. Often these crimes are committed while the juvenile is under the influence of alcohol or other drugs, or in the context of domestic violence. The Division has adopted a new risk and needs assessment tool to better work with juveniles to address the root causes of their law-breaking behavior, and will continue to review and incorporate research-based practices as it seeks to improve its outcomes for youth on probation supervision.

Note: Reoffenses for juveniles released from formal probation are determined by checking for entries in the Division's Juvenile Offender Management Information System and the Alaska Public Safety Information Network. This table reports the number of youth for whom court-ordered probation episodes closed during the fiscal year for one of the following reasons: Completed Successfully, Order Expired, Non-compliant Closed, Waived to Adult Status, Declared Incompetent, or Deceased. Youth whose formal probation ends because of Court Termination Resulting in a new Supervision, Modified, Revoked, or Supervision Transfer are not included. This analysis also excludes youth who were ordered to an Alaska treatment institution, as these youth are included in the analysis for our institutional recidivism performance measure, above. Reoffenses are defined as offenses resulting in a new juvenile adjudication or an adult conviction. Adjudications and convictions for Motor Vehicle, Fish & Game, non-habitual violations of Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudications and convictions received outside Alaska are excluded from analysis. To be counted as recidivists, youth must have committed an offense within 12 months of their release date, and the offense must have resulted in an adult conviction or new juvenile adjudication.

**Target #3:** Alaska's juvenile crime rate will be reduced by 5% over a two-year period.

**Measure #3:** Percentage change of Alaska juvenile crime rate compared to the rate one and two years earlier.



REGION	DISTRICT	Juveniles	Referrals	Charges
ANCHORAGE	ANCHORAGE	1531	2111	3221
<b>ANCHORAGE Total</b>		<b>1531</b>	<b>2111</b>	<b>3221</b>
NORTHERN	BARROW	44	78	141
	BETHEL	227	368	768
	FAIRBANKS	458	662	1170
	KOTZEBUE	103	171	430
	NOME	104	172	301
<b>NORTHERN Total</b>		<b>937</b>	<b>1451</b>	<b>2810</b>
SOUTHCENTRAL	DILLINGHAM	90	129	228
	HOMER	52	70	122
	KENAI	273	394	632
	KODIAK	81	131	267
	MAT-SU	367	477	865
	VALDEZ	44	55	109
<b>SOUTHCENTRAL Total</b>		<b>907</b>	<b>1256</b>	<b>2223</b>
SOUTHEAST	JUNEAU	270	458	713
	KETCHIKAN	154	240	417
	PETERSBURG	18	27	49
	PRINCE OF WALES	30	37	64
	SITKA	54	75	126
<b>SOUTHEAST Total</b>		<b>526</b>	<b>837</b>	<b>1369</b>
<b>Grand Total</b>		<b>3901</b>	<b>5655</b>	<b>9623</b>

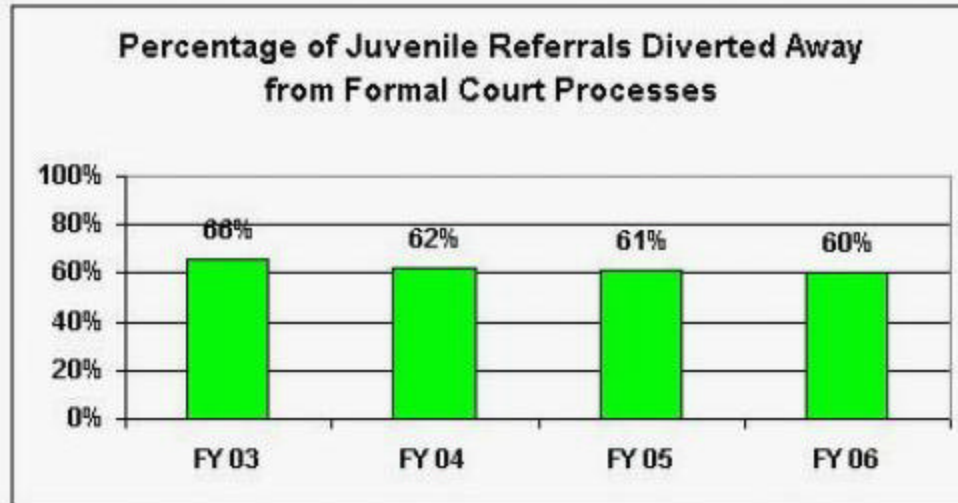
**Analysis of results and challenges:** The number of referrals and the percentage of these referrals per 100,000 juvenile population was very slightly reduced in FY 06 compared with FY 05, representing virtually no statistical difference between these years. Nevertheless, the target of reducing referrals by 5% from two years prior (FY 04) was surpassed. Definitive reasons for changes in referral levels are unknown, although possible causes could include changes in economic conditions, changes in prevention and intervention techniques, changes in law enforcement practices or resources, or a combination of some or all of these.

Note: Population data is based on estimates for the previous fiscal year (FY 05) from the Alaska Department of Labor. Juvenile referral data was extracted from the Division of Juvenile Justice's Juvenile Offender Management

Information System (JOMIS) database on August 1, 2006 and includes referrals for youth who are under 10 years old (these referrals make up less than 1% of the total). This data is continually refined and corrected and numbers in future reports may change slightly.

**Target #4:** Divert at least 60% of youth referred to the Division away from formal court processes as appropriate given their risks, needs, and the seriousness of their offenses.

**Measure #4:** The percentage of referrals that are managed through informal processes.



**Analysis of results and challenges:** In FY 06 the proportion of juvenile referrals (reports from law enforcement that allege a juvenile perpetrator) that were diverted from the formal court process remained high, at 60%. This means that approximately 2,360 juveniles out of the total 3,929 that entered the juvenile justice system in FY 06 had their cases managed through non-court adjustments, informal probation, referral to community panels such as youth court, or were dismissed.

Diversion of youth from formal court processing serves a number of important, valuable purposes. It helps low-risk juveniles who are unlikely to re-offend avoid the stigma and needless harm that can result from delinquency adjudication. Diversion can provide opportunities for community partners and victims to take more active roles in addressing low-risk juvenile offenders. Diversion processes reduce burdens on the court system, which otherwise would find it impossible to adjudicate every offender referred to them. Diversion is a considerably less expensive and faster process than the formal adversarial court process and reduces probation caseloads as well, enabling the Division to better allocate resources and staff time to more serious offenders.

**Note:** For this measure, youth are considered to have been diverted away from the formal court system if the intake decision for their delinquency referral results in the referral being adjusted, dismissed, placed on informal probation, or forwarded to a community justice panel such as youth court. Additionally, diverted would include those referrals that are screened and referred elsewhere (1% of total in FY06), such as back to law enforcement for further information, and those that were still in process (4% of the total in FY06) at the time this data was collected.

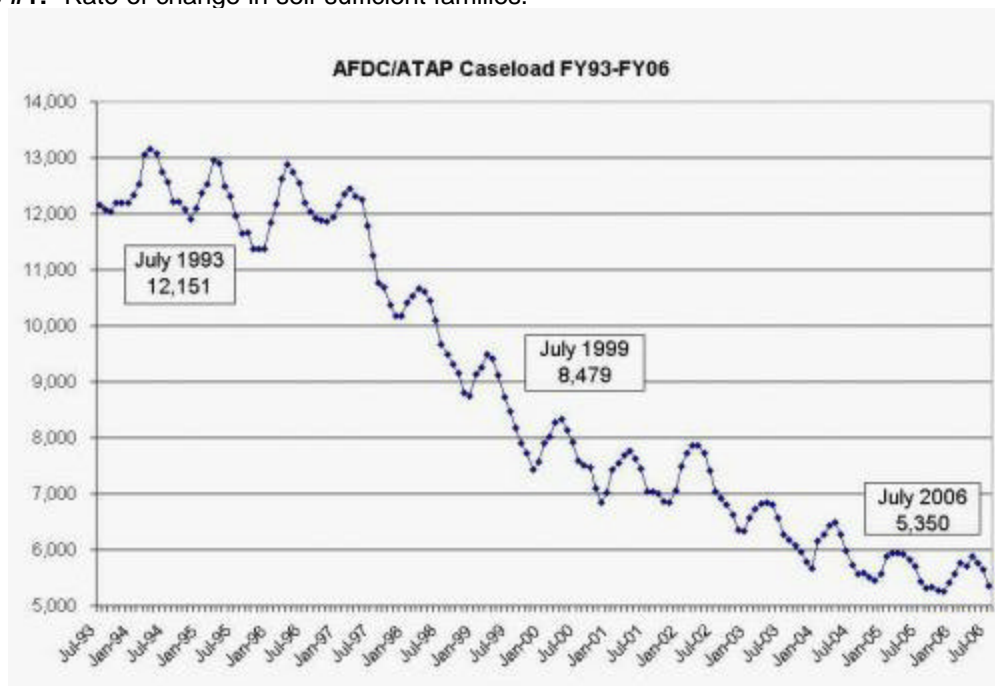
\*Referral: A request for a Division of Juvenile Justice response service following the arrest of a juvenile or submission of a police investigation report alleging the commission of a crime or violation of a court order by a juvenile offender.

**E1: Strategy - Implement and review information from research-based assessment tools, and incorporate practices proven to reduce recidivism and criminal behavior among youth.**

**F: Result - Outcome Statement #6: Low income families and individuals become economically self-sufficient.**

**Target #1:** Increase self-sufficient individuals and families by 10% annually.

**Measure #1:** Rate of change in self-sufficient families.



\*Table includes ATAP & Native Family Assistance Programs

#### Changes in Self Sufficiency

Fiscal Year	September	December	March	June	YTD Total
FY 2002	-16%	6%	4%	3%	-2%
FY 2003	-1%	-11%	-14%	-13%	-9%
FY 2004	-12%	-7%	-6%	-9%	-9%
FY 2005	-6%	-7%	-8%	-6%	-7%
FY 2006	-6%	-3%	-4%	-1%	-2%
FY 2007	-5%	0	0	0	-5%
		0%	0%	0%	

\*YTD Total column represents the average annual monthly caseload rate change.

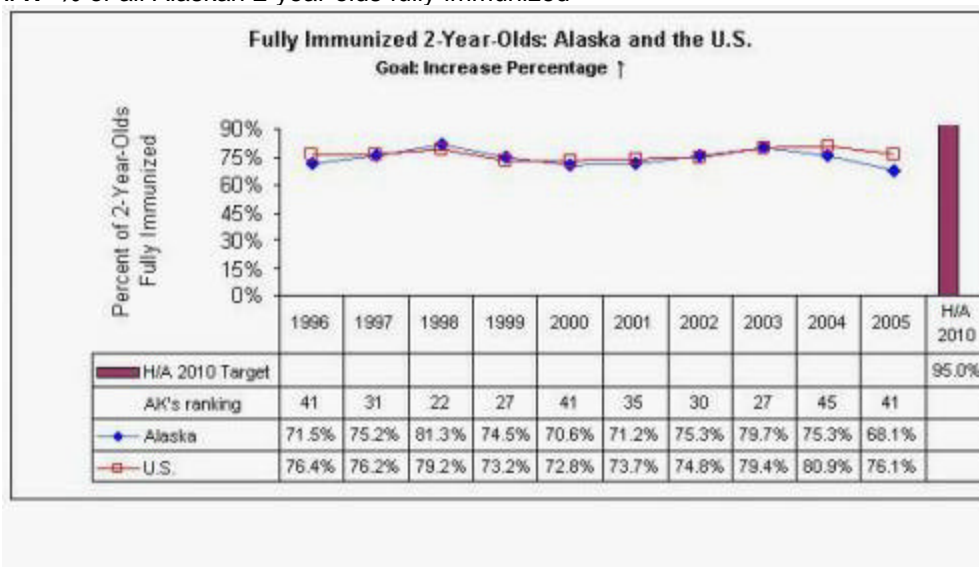
**Analysis of results and challenges:** As shown in the YTD Total column, SFY2006 had a 2% decline in the number of families receiving Alaska Temporary Assistance Program benefits compared to SFY2005. The other four monthly columns show a snapshot of caseload rate change compared to the previous year's month. (Note: The YTD Total column represents the average annual monthly caseload rate change.)

The goal is for clients to move off of Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the program. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of families becoming self-sufficient.

**F1: Strategy - Use TANF high performance bonus funds for families approaching 60-month time limit.**
**G: Result - Outcome Statement #7: Healthy people in healthy communities**

**Target #1:** 80% of all 2 year olds are fully immunized

**Measure #1:** % of all Alaskan 2 year olds fully immunized


**Vaccination Coverage Among Children 19-35 Months of Age, Alaska and US**

Year	US %	Alaska %	AK US Rank
1999	73.2	74.5	27
2000	72.8	70.6	41
2001	73.7	71.2	35
2002	74.8	75.3	30
2003	79.4	79.7	27
2004	80.9	75.3	45
2005	76.1	68.1*	41

**Analysis of results and challenges:** Chart Note: Source - National Immunization Survey, Centers for Disease Control and Prevention. Annual percentages are based on CDC recommendations at the time, which have changed over the years as vaccines have been added to the "basic immunization series."

\* In 2005, the CDC increased its recommendation to a new, six-dose series of vaccinations. As a result, the national rate of fully immunized two year olds dropped considerably, as did Alaska's rate. However, Alaska's ranking amongst states increased slightly, from 45th in 2004 to 41st in 2005. These results continue to illustrate the need for renewed emphasis on the importance of timely immunizations for young children.

**Target #2:** Reduce post-neonatal death rate to 2.7 per 1,000 live births by 2010

**Measure #2:** Three year average post-neonatal mortality rate (Post-neonatal is defined as 28 days to 1 year)



#### Post-Neonatal Death Rate - AK and US

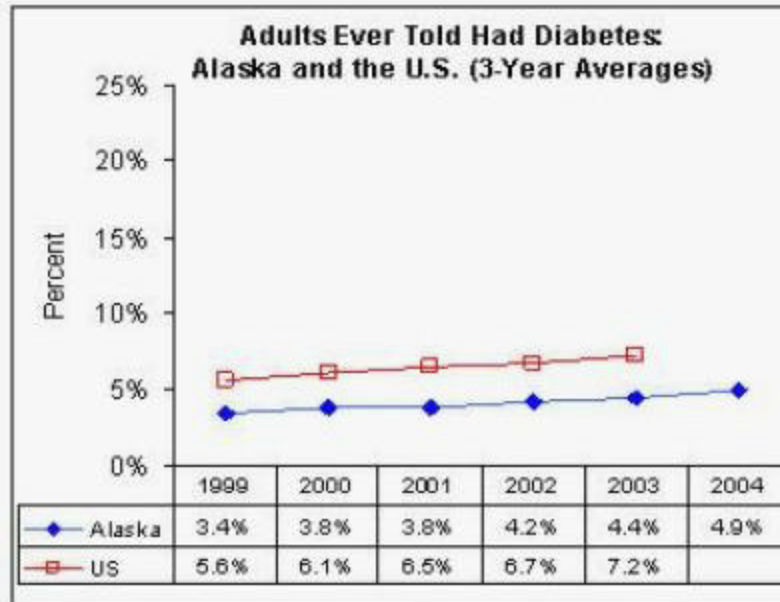
Year	Alaska	US
1999	3.0	2.3
2000	3.2	2.3
2001	4.5	2.3
2002	3.6	2.3
2003	3.8	2.2
2004	3.2	2.3
2005	2.8	N/A

Note: The 2005 US death rate will not be available until late in 2006 or early 2007.

**Analysis of results and challenges:** Chart Note: Rate per 1,000 Live Births and reflects three year rate, i.e. 2003 represents 2001-2003.

Post-neonatal mortality is more often caused by environmental conditions than problems with pregnancy and childbirth. Nationally, the leading causes of death during the post-neonatal period (28 through 364 days) during 2002 were Sudden Infant Death Syndrome (SIDS), birth defects, and unintentional injuries. The post-neonatal mortality rate in Alaska is higher than the national target of 1.5 per 1,000 live births (Healthy People 2010) and has remained relatively static over time. While not shown graphically, over the last decade Alaska Native infants were 2.3 times more likely to die during the post-neonatal period than Caucasian infants.

Work by DHSS is underway with the Indian Health Service on a rural initiative to prevent Sudden Infant Death Syndrome (SIDS). Also, cessation efforts involving tobacco, alcohol and other drugs are being targeted on the pre-conception and prenatal periods. Finally, work has begun with health providers and community partners to establish a model program of early prevention and chronic disease management for prenatal patients.

**Target #3:** Decrease diabetes in Alaskans**Measure #3:** Prevalence of Diabetes among Adults (18+) in Alaska based upon three-year averages**Est Annual Prevalence of Diabetes among Adults (18+) in Alaska Based upon Midpoints of Three-Year Averages**

Year	Alaska	US
1999	3.4%	5.6%
2000	3.8%	6.1%
2001	3.8%	6.5%
2002	4.2%	6.7%
2003	4.4%	7.2%
2004	4.9%	N/A

Note: 2004 Alaska data is based on a 3 year average of 2003-2005.

**Analysis of results and challenges:** Data Source: BRFSS - Behavioral Risk Factor Surveillance System

Diabetes is a chronic disease characterized by high levels of blood glucose. Type 2 diabetes accounts for 90 to 95 percent of all diagnosed cases and typically occurs in adults, but is increasingly being diagnosed in children and adolescents. Type 2 diabetes usually begins as insulin resistance, a condition in which the cells do not use insulin properly. Risk factors for Type 2 diabetes include older age (40-plus years), obesity, family history of diabetes, prior history of gestational diabetes, impaired glucose metabolism, physical inactivity, and race/ethnicity.

Diabetes is the leading cause of blindness and end-stage renal disease in adults. Diabetes increases the risk of heart disease, stroke, and many infectious diseases. Nerve damage from diabetes is the leading cause of lower extremity amputations. Diabetes prevalence increases with age, and the prevalence of diabetes in the United States is expected to increase as the population ages.

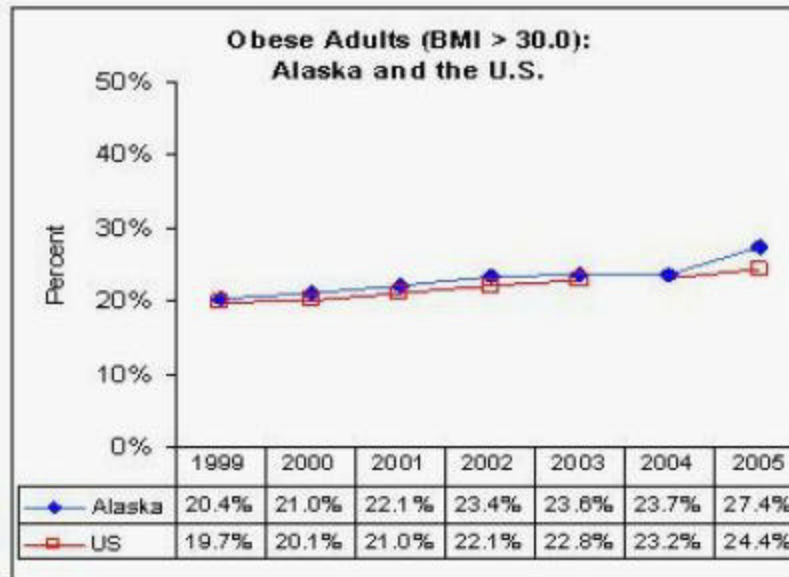
Over the past decade, an increasing number of Alaskan adults have reported being told by a health professional that they have diabetes. This number, plus the estimated 29% of all diabetes cases that go undiagnosed, yields the best estimate of the true prevalence of diabetes in Alaska. One limitation of this estimate is that, with improving surveillance and detection, prevalence will continue to increase independent of any real increase in

morbidity.

The Department works to reduce the health burden and economic costs of diabetes in Alaska through an integrated program of prevention and disease management that supports individuals and communities. To slow or halt the upward trend of diabetes, a comprehensive approach is needed to make healthy behaviors the norm. The major risk factors contributing to chronic diseases are tobacco use, physical inactivity, unhealthy eating habits and resulting obesity. The Department will address all of these factors by giving individuals the knowledge and tools they need to make healthier choices, while also assuring that healthy behaviors are reinforced in schools, worksites and other community settings.

**Target #4:** Decrease Alaska's adult obesity rate to less than 18%

**Measure #4:** Obesity rate of Alaskans



#### Prevalence of Obesity: Alaska & US

Year	Alaska	US
1999	20.4%	19.7%
2000	21.0%	20.1%
2001	22.1%	21%
2002	23.4%	22.1%
2003	23.6%	22.8%
2004	23.7%	23.2%
2005	27.4%	24.4%

**Analysis of results and challenges:** The trends in Alaska continue to show growing numbers of overweight and obese adults, with a significant increase in obesity in 2005, to 27.4%. By comparison, the Healthy Alaskans 2010 target for obesity is 18%.

Premature death and disability, increased health care costs, and lost productivity are all associated with overweight and obesity. Unhealthy dietary habits combined with sedentary behavior are primary factors in increasing body fat levels. Overweight and obesity are estimated to be responsible for approximately 300,000 deaths per year in the United States.

National studies show an association of overweight and obesity with certain types of cancers (endometrial, colon, post menopausal breast, and prostate), as well as heart disease, stroke, diabetes and arthritis. Overweight and obesity are directly associated with at least four of the top ten leading causes of death. Mortality due to unintentional injury, suicide, chronic obstructive pulmonary disease (COPD), pneumonia, and liver disease may also be influenced by obesity to some extent.

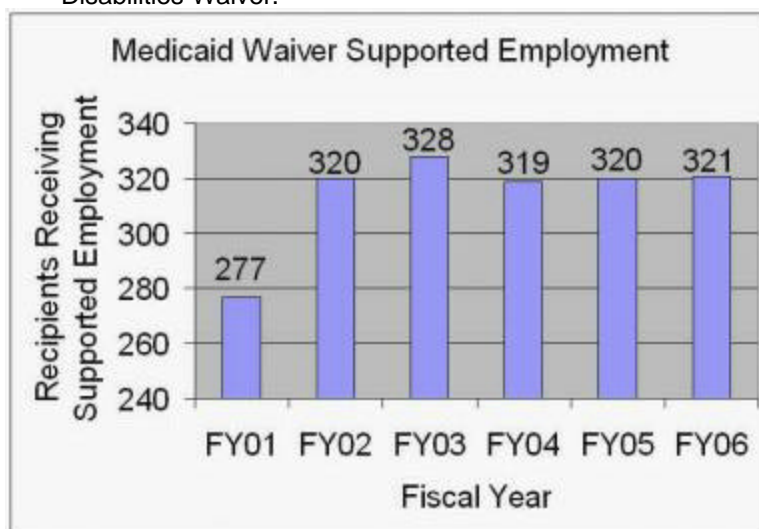
Through educational, programmatic, policy and environmental strategies, the Department works to reduce the percentage of Alaskans classified as overweight, obese or at-risk for being overweight, and to promote healthy food choices and exercise. A comprehensive approach is needed to reduce the trend of increasing obesity in Alaska. Along with tobacco use, physical inactivity and unhealthy eating habits, obesity contributes greatly to the prevalence of chronic disease. The Department is working to address all of these factors by giving individuals the knowledge and tools they need to make healthier choices. Strategies also are targeted to promote healthy behaviors in communities - the workplace, schools and other settings.

### G1: Strategy - Strengthen public health in strategic areas.

### H: Result - Outcome Statement #8: Senior and physically and/or developmentally disabled Alaskans live independently as long as possible.

**Target #1:** Increase the number of DD waiver recipients receiving Supported Employment Services.

**Measure #1:** % change of beneficiaries receiving supported employment services under Developmental Disabilities Waiver.



#### % Change in Recipients Receiving Supported Employment

Fiscal Year	% Change
FY 2002	15.5%
FY 2003	2.5%
FY 2004	-2.7%
FY 2005	0.3%
FY 2006	0.3%

**Analysis of results and challenges:** Supported Employment Services is one of the best resources available to developmentally disabled beneficiaries to help them live independently by providing them with the opportunity to work. The Division of Senior and Disabilities Services has determined that the reason the number of DD waiver beneficiaries receiving supported employment has reached a plateau in recent years is because only the highest-functioning clients without behavioral issues can be easily employed. In FY07 and beyond, the Division will be working with the Governor's Council on Disabilities and Special Education to increase participation in supported employment as outlined in the Alaska Works Initiative 2006-2010 Strategic Plan.

# H1: Strategy - Promote independent living and provide preadmission screening to nursing homes.

## I: Result - Outcome Statement #9: The efficient and effective delivery of administrative services.

**Target #1:** Increase by 5% the percentage of customers that report Finance and Management Services (FMS) is meeting their needs.

**Measure #1:** Percentage of customer service internal survey respondents that report FMS is meeting their needs.

### % of Survey Respondents rating that FMS met their needs

Year	FMS Overall %	% Change	Avg % of All Services	% Change
2003	58.7%	0.0%	70.6%	0.0%
2004	64.7%	6.0%	70.6%	0.0%
2005	64.0%	-0.7%	71.5%	0.9%

**Analysis of results and challenges:** An internal customer survey on Finance and Management Services (FMS) performance is conducted annually. The 2006 survey has not yet been completed.

Survey results show that 64.0% of survey respondents ranked overall FMS service performance to be above average (6) or higher on a scale of 1-10.

Individual core services are surveyed; however, only the overall results are shown in the above table. You can reference the specific program areas reported at the division level Result B, Target 1, Measure 1. Combined average of respondents agreeing or highly agreeing that core services are meeting their needs is 71.5% for 2005, an increase of 0.9% over 2004. This is compared to a 0% increase from FY03 to FY04.

The long-term target is to increase the percentage of respondents showing that FMS is meeting their needs by 5% from the base year of 2003.

Although the department saw increased results in some service areas from FY04 to FY05, the overall percentage did meet expectations. Finance and Management Services conducted Business Process Reviews in FY05 on all services provided and is in the process of implementing recommendations from those reviews. We anticipate that these improvement areas, i.e. finance, budget and revenue, will help increase respondent ratings in FY06.

**Target #2:** Reduce the average response time for complaints/inquiries to 14 days.

**Measure #2:** Department Inquiry/Complaint "HSS Track" log response times.

### # of Inquiries/Complaints

Fiscal Year	Opened	Closed	Avg Days to Close
FY 2005	552	503	15.18
FY 2006	1590	1408	25.78
FY 2007	323	282	10.39

*FY2007-represents the first quarter of FY2007.*

**Analysis of results and challenges:** The response log "HSS Track" includes all inquiries or complaints that are received by the DHSS Commissioner's Office (i.e., public or legislative complaints, legislative questions, press inquiries, etc.).

The increase in the inquiries/complaints opened in FY06 is attributed to the fact that in FY05 only a limited number of sections in the department were utilizing the log. In FY06, the Office of Children's Services was added to the HSS Track. This greatly increased the number and complexity involved to close out inquiries.

The response log "HSS Track" will be monitored by the Commissioner's Office.

**Target #3:** Reduce by 5% per year processing time for key indicators.

**Measure #3:** Track number of days it takes to process: Purchase Requisitions; Operating Grant Awards; Processing Time for Payments; Capital Grant Awards; and Legislative inquiries.

Timeliness and Accuracy		
Fiscal Year 2006		
	# Processed	Days to Process
Purchase Requisitions	507	7.00
Operating Grant Awards	610	19.12
DHSS Invoices	158,281	9.33
Capital Grant Awards	93	3.36
Legislative Logs	172	3.52

**Analysis of results and challenges:** This is a new indicator with new data for FY2006. The data will develop a baseline for future comparisons.

## I1: Strategy - Implement results of Business Process Review.

### Prioritization of Agency Programs

(Statutory Reference AS 37.07.050(a)(13))

1. Alaska Psychiatric Institute
2. Protection and Community Services
3. Epidemiology
4. Alaska Temporary Assistance Program
5. Tribal Assistance Programs
6. Pioneer Homes
7. HCS Medicaid Services
8. Senior and Disabilities Medicaid Services
9. Behavioral Health Medicaid Services
10. Children's Medicaid Services
11. Senior Care
12. Probation Services
13. Adult Public Assistance
14. Community Developmental Disabilities Grants
15. Foster Care Base Rate
16. Foster Care Augmented Rate
17. Foster Care Special Need
18. McLaughlin Youth Center
19. Delinquency Prevention
20. Fairbanks Youth Facility
21. Johnson Youth Center
22. Bethel Youth Facility
23. Nome Youth Facility
24. Ketchikan Regional Youth Facility
25. Mat-Su Youth Facility
26. Kenai Peninsula Youth Facility
27. Public Health Laboratories
28. Residential Child Care
29. Psychiatric Emergency Services
30. Behavioral Health Grants
49. Infant Learning Program Grants
50. Youth Courts
51. Certification and Licensing
52. State Medical Examiner
53. Senior Residential Services
54. General Relief Assistance
55. Community Health Grants
56. Community Action Prevention & Intervention Grants
57. Designated Evaluation and Treatment
58. Commissioner's Office
59. Administrative Support Services
60. Facilities Management
61. Office of Program Review
62. Information Technology Services
63. Rate Review
64. Quality Control
65. Fraud Investigation
66. Hearings and Appeals
67. Governor's Advisory Council on Faith-Based and Community Initiatives
68. Health Planning & Infrastructure
69. Facilities Maintenance
70. Pioneers Homes Facilities Maintenance
71. Children's Services Training
72. Public Assistance Field Services
73. Child Protection Legal Svcs
74. Community Health/Emergency Medical Services
75. Tobacco Prevention and Control
76. Assessment and Planning (Medicaid)
77. Women, Children & Family Health

- |   |   |
|---|---|
| 31. Rural Services and Suicide Prevention             | 78. Medicaid School Based Administrative Claims     |
| 32. Services for Severely Emotionally Disturbed Youth | 79. HSS State Facilities Rent                       |
| 33. AK Fetal Alcohol Syndrome Program                 | 80. Alaskan Pioneer Homes Management                |
| 34. Services to the Seriously Mentally Ill            | 81. Behavioral Health Administration                |
| 35. Catastrophic and Chronic Illness Assistance       | 82. Children's Services Management                  |
| 36. Nursing   | 83. Medical Assistance Administration               |
| 37. Adult Preventative Dental Medicaid Svcs           | 84. Public Assistance Administration                |
| 38. Subsidized Adoptions & Guardianship               | 85. Public Health Administrative Services           |
| 39. Child Care Benefits                               | 86. Senior and Disabilities Services Administration |
| 40. Work Services                                     | 87. Permanent Fund Dividend Hold Harmless           |
| 41. Chronic Disease Prevention/Health Promotion       | 88. Council on Faith Based & Community Initiatives  |
| 42. Energy Assistance Program                         | 89. Children's Trust Programs                       |
| 43. Bureau of Vital Statistics                        | 90. Alcohol Safety Action Program (ASAP)            |
| 44. Emergency Medical Services Grants                 | 91. Alaska Mental Health/Alcohol & Drug Abuse Brds  |
| 45. Human Services Community Matching Grant           | 92. Commission on Aging                             |
| 46. Senior Community Based Grants                     | 93. Governor's Council on Disabilities              |
| 47. Women, Infants and Children                       | 94. Pioneers Homes Advisory Board                   |
| 48. Family Preservation                               | 95. Suicide Prevention Council                      |

## Alaska Pioneer Homes Results Delivery Unit

### Contribution to Department's Mission

Provide the highest quality of life in a safe home environment for older Alaskans and veterans.

### Core Services

Provide residential assisted living services.

End Results	Strategies to Achieve Results
<b>A: Outcome statement - Eligible Alaskans and Veterans will live in a safe environment.</b>  <u>Target #1:</u> Reduce resident serious injury rate. <u>Measure #1:</u> Hold constant, below the national level, the number of medication errors and falls that result in serious injury.	<b>A1: 1) Improve the medication dispensing and administration system.</b>  <u>Target #1:</u> Less than one percent medication error rate, which is one-half the low end of the national standard range. <u>Measure #1:</u> Percent of medication administration errors.  <b>A2: 2) Reduce the number of residents' serious injuries from falls.</b>  <u>Target #1:</u> Less than two percent injury rate, which is the low end of the National Safety Council's range of two to six percent. <u>Measure #1:</u> Percent of Pioneer Homes serious injuries from falls.

FY2008 Resources Allocated to Achieve Results		
FY2008 Results Delivery Unit Budget: \$54,951,800	<b>Personnel:</b>	
	Full time	554
	Part time	49
	<b>Total</b>	<b>603</b>

### Performance Measure Detail

**A: Result - Outcome statement - Eligible Alaskans and Veterans will live in a safe environment.**

**Target #1:** Reduce resident serious injury rate.

**Measure #1:** Hold constant, below the national level, the number of medication errors and falls that result in serious injury.

**Analysis of results and challenges:** Increasing age and acuity levels of Pioneer Homes residents creates a challenge in reducing adverse events that result in serious injury. By properly utilizing the strength of trending and tracking information available in the Division's risk analysis program, the Homes are able to identify times,

places, staff and conditions that hold inherent risk. Action plans to address risk help the Homes prevent errors, reduce the number of serious injury events, and reduce the severity of injury.

See Link below for data.

### A1: Strategy - 1) Improve the medication dispensing and administration system.

**Target #1:** Less than one percent medication error rate, which is one-half the low end of the national standard range.

**Measure #1:** Percent of medication administration errors.

#### Medication Error Rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2002	0.07%	0.08%	0.04%	0.05%	0.06%
2003	0.10%	0.11%	0.09%	0.15%	0.11%
2004	0.07%	0.11%	0.06%	0.07%	0.08%
2005	0.08%	0.09%	0.09%	0.14%	0.10%
2006	0.19%	0.15%	0.16%	0.12%	0.17%
2007	0.19%	0	0	0	0
		0%	0%	0%	0%

The medication error rate is calculated by taking the number of medication errors per quarter divided by the total number of medications taken by all Pioneer Home residents in the same quarter.

**Analysis of results and challenges:** The Centers for Medicare and Medicaid Services, which licenses nursing facilities throughout the United States, considers a five percent medication error rate acceptable.

The Pioneer Home system collects medication information at the individual Pioneer Home level and aggregates the numbers for reporting at the Division level. In 2006, Pioneer Home staff administered an average of 434,464 individual medications each quarter.

All care processes are vulnerable to error, yet several studies have found that medication-related activities are the most frequent type of adverse event. Medication administration errors are the traditional focus of incident reporting programs because they are often the types of events that identify a failure in other processes in the system. A wrong medication may be administered because it was prescribed, transcribed, or dispensed incorrectly. The Division uses a system wide risk reporting program that tracks medication errors, and allows the collected data to be reported and trended for use in identifying error prone steps (risks). Trending the cause of the error tends to provide the most useful information in designing strategies for future error prevention.

### A2: Strategy - 2) Reduce the number of residents' serious injuries from falls.

**Target #1:** Less than two percent injury rate, which is the low end of the National Safety Council's range of two to six percent.

**Measure #1:** Percent of Pioneer Homes serious injuries from falls.

#### Sentinel Event injury rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2002	2.9%	0.7%	0.0%	0.37%	0.99%
2003	1.1%	0.04%	1.79%	1.5%	1.1%
2004	1.96%	1.26%	0.97%	1.47%	1.45%
2005	2.6%	2.4%	1.5%	2.3%	2.2%
2006	0.6%	2.7%	1.3%	1.1%	1.43%
2007	4.0%	0	0	0	0
		0%	0%	0%	0%

The Sentinel Event Injury rate reports the percentage of falls that result in a major injury. The rate is calculated by dividing the number of Sentinel Event injuries to Pioneer Homes residents by the total number of falls reported for the same quarter.

**Analysis of results and challenges:** Seventy-five percent of elderly deaths result from falls.

Despite remarkable advances in almost every field of medicine, the age-old problem of health-care errors continues to haunt health care professionals. When such errors lead to "sentinel events," those with serious and undesirable occurrences, the problem is even more disturbing. The event is called sentinel because it sends a signal or warning that requires immediate attention. One in three people age 65 and older, and 50 percent of those 80 and older fall each year. The National Safety Council lists falls in older adults as five times more likely to lead to hospitalization than other injuries. One estimate suggests that direct medical costs for fall-related injuries will rise to \$32.4 billion by 2020. Falls can have devastating outcomes, including decreased mobility, function, independence, and in some cases, death.

The average age of Pioneer Homes residents is 84.9 putting them in the highest risk category where they are more likely to suffer a serious injury from a fall and experience significant morbidity thereafter.

The Pioneer Homes responds to serious injuries with root cause analysis investigations and corrective action plans to address underlying causes.

The analysis of the spike in sentinel event injuries between FY04 and FY05 does not indicate one root cause. There were, however, seven deaths associated with falls in FY05\*. Of the total, six of the seven falls occurred when the resident was alone so they are categorized as unwitnessed. It is difficult to recreate the events leading up to an unwitnessed fall, especially if the fall involves a resident who suffers from dementia and is unable to articulate what occurred. Most of these falls are reported as "found on floor," and the sequence of events leading up to the fall reconstructed by staff depending on the time of day with some supposition on the activity the resident was attempting.

Because such a significant number of the witnessed falls are less severe than unwitnessed falls, the division built a case for increased staffing with the intention of reducing the number of falls that are unwitnessed. Three new positions were funded in FY06 and the table below shows a 2 percent decrease in the overall percentage of unwitnessed falls.

	Unwitnessed Fall Rate
FY05	81%
FY06	79%

Twenty-four new positions were funded for nine months in FY07, beginning October 1, 2006, so there are no correlating statistics for the first quarter.

\*Any death within 45 days of a sentinel event is associated with that event.

## Behavioral Health Results Delivery Unit

### Contribution to Department's Mission

The mission of the Division of Behavioral Health is to provide an integrated behavioral health system.

### Core Services

The Division of Behavioral Health was the result of combining the mental health portion of the Division of Mental Health and Developmental Disabilities, the Division of Alcoholism and Drug Abuse, and the Office of Fetal Alcohol Syndrome. Its primary function is to provide treatment and prevention services for Alaskans with substance use disorders, mental illness, or a combination of both. There are also special sections devoted to behavioral health problems caused by traumatic brain injury and fetal alcohol spectrum disorders.

This RDU provides the overall administrative and organizational structure to grant and monitor the use of funds to support treatment and prevention services for substance abuse, mental illness and those at risk for these conditions. RDU functions include service system planning and policy development, programmatic oversight of behavioral health grantees' service provision, general administration, budget development and fiscal management, and development and program staff support of grantees in training and implementation of the Alaska Automated Information Management System (AKAIMS). The leadership in this RDU works closely with the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Trust Authority to determine policy governing the planning and implementation of services and supports for people who experience mental illness, substance abuse disorders, or both. Direct services include quality assurance, technical assistance, and consultation.

This RDU also provides centralized support for the Alaska Psychiatric Institute. API is located in Anchorage, and is the only publicly funded facility providing high level inpatient psychiatric care to the people of Alaska. These services are available when no other service is adequate to meet the needs of a severely ill individual or individual in crisis. It is a seven-day-a-week, 24-hour-a-day treatment facility. Clients are admitted either voluntarily or involuntarily through a Peace Officer Application or Ex Parte Commitment. API provides diagnosis, evaluation and treatment services in accordance with its statutory mandates and the strict health care industry standards and requirements set by the Joint Commission on Accreditation of Healthcare Organizations, Centers for Medicare and Medicaid Services, and the State of Alaska's Certification and Licensing section. API provides outreach, consultation, and training to mental health service providers, community mental health centers, and Pioneer Homes. In addition, API serves the entire Alaska community mental health system, including coordinating the transition of patients between inpatient and outpatient care, when appropriate.

End Results	Strategies to Achieve Results
<p><b>A: Outcome #1: Improve and enhance the quality of life for Alaskans with a serious emotional disturbance (SED), a serious mental illness (SMI) and/or a substance abuse disorder.</b></p> <p><u>Target #1:</u> 75% of individuals will report improvement in one or more of the following life domains: productive activity/employment, housing situation, health status, economic security, education attained.</p> <p><u>Measure #1:</u> Outcomes data as reported through the use of the Client Status Review Form as part of the Federal Government Performance and Results Act.</p>	<p><b>A1: Strategy #1A: Improve and enhance the quality of life of children with a SED by implementing the Bring the Kids Home Program.</b></p> <p><u>Target #1:</u> Reduce the number of kids in out-of-state placement by 25% annually over the next four years.</p> <p><u>Measure #1:</u> Change in percent of children reported in out-of-state care from Medicaid MMIS.</p> <p><b>A2: Strategy #1B: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder by implementing the DH&amp;SS Tribal Agenda.</b></p> <p><u>Target #1:</u> Increase the number of Tribal entities providing behavioral health services to Alaska Natives by 10% annually for each of the next four years.</p>

	<p><b>Measure #1:</b> Number of Tribal entities providing behavioral health services directly or contracting with non-Tribal providers for those services</p> <p><b>A3: Strategy #1C: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder through the development of a comprehensive, integrated Behavioral Health Service System.</b></p> <p><u>Target #1:</u> A fully integrated Behavioral Health Service system will occur over the next four years as evidenced by a 25% improvement in service outcomes and consumer satisfaction.</p> <p><u>Measure #1:</u> Treatment satisfaction data from Mental Health Statistics Improvement Program (MHSIP) Consumer Survey.</p>
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### FY2008 Resources Allocated to Achieve Results

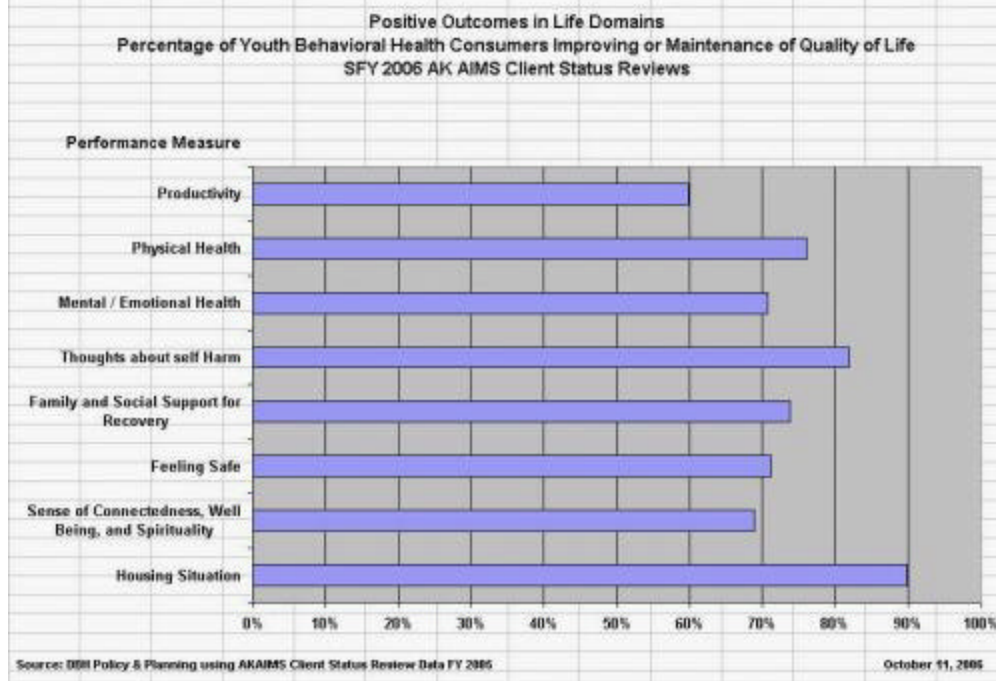
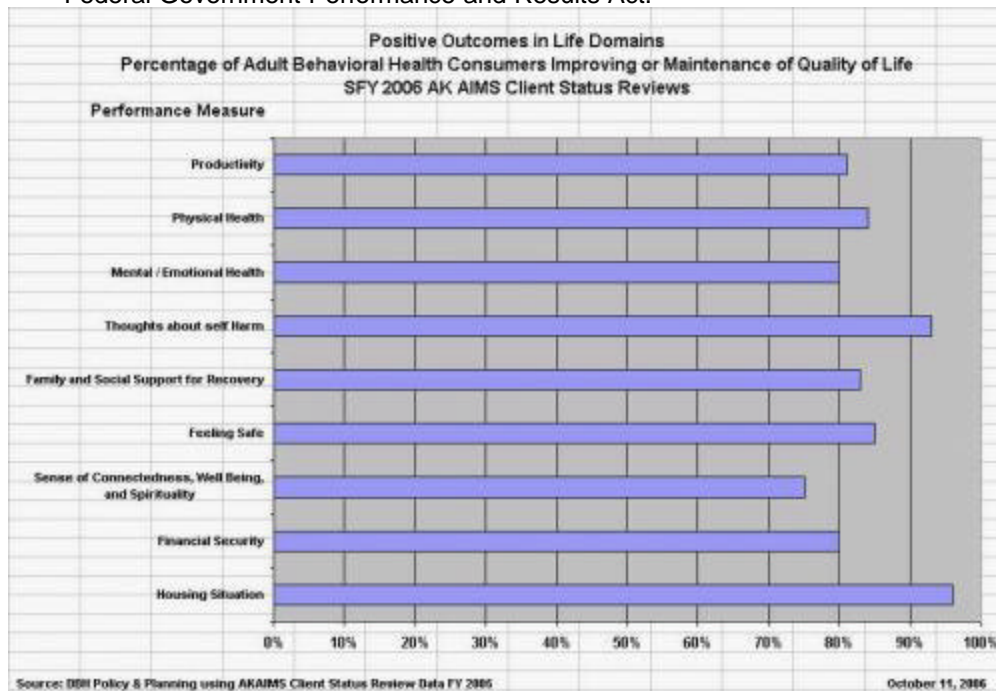
<b>FY2008 Results Delivery Unit Budget: \$271,903,000</b>	<b>Personnel:</b>	
	Full time	293
	Part time	14
	<b>Total</b>	<b>307</b>

## Performance Measure Detail

**A: Result - Outcome #1: Improve and enhance the quality of life for Alaskans with a serious emotional disturbance (SED), a serious mental illness (SMI) and/or a substance abuse disorder.**

**Target #1:** 75% of individuals will report improvement in one or more of the following life domains: productive activity/employment, housing situation, health status, economic security, education attained.

**Measure #1:** Outcomes data as reported through the use of the Client Status Review Form as part of the Federal Government Performance and Results Act.



**Analysis of results and challenges:** The ability to determine treatment outcomes for clients of our mental health and substance abuse services is a relatively new and exceptionally useful tool. Not long ago, "is he still sober?" or "is she taking her meds?" were the only measures of success that behavioral health programs used: crude measures at best, and misleading at worst. Just as mental illness and substance abuse affects all areas of a person's life, so does recovery affect more than just a single variable. Therefore, clients of our programs are asked questions at entry, discharge, and at various points post-discharge, concerning a variety of "life domains." By comparing these responses, we are offered a picture of change in a person's life, regarding productivity (jobs, homemaking, student activity, subsistence activity, etc.), physical health, mental/emotional health, suicidality, social and family supports, safety, spirituality, finances, and housing.

**A1: Strategy - Strategy #1A: Improve and enhance the quality of life of children with a SED by implementing the Bring the Kids Home Program.**

**Target #1:** Reduce the number of kids in out-of-state placement by 25% annually over the next four years.

**Measure #1:** Change in percent of children reported in out-of-state care from Medicaid MMIS.

**Analysis of results and challenges:** This measure is reported at the Department level.

**A2: Strategy - Strategy #1B: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder by implementing the DH&SS Tribal Agenda.**

**Target #1:** Increase the number of Tribal entities providing behavioral health services to Alaska Natives by 10% annually for each of the next four years.

**Measure #1:** Number of Tribal entities providing behavioral health services directly or contracting with non-Tribal providers for those services

**# of Tribal Entities**

Fiscal Year	# Providing Service
FY 2004	4
FY 2005	8
FY 2006	14

**Analysis of results and challenges:** During SFY 2004, there were four Tribal entities providing and billing for behavioral health services. During SFY 2005 the number of Tribal entities providing and billing for behavioral health services increased to 8. These include Bristol Bay Area Health Corp., Copper River Native Assoc., Kenaitze Indian Tribe, Maniilaq Assoc., Norton Sound Health Corp., Southcentral Foundation, Tanana Chiefs Conference, Yukon Kuskokwim Health Corp.

In 2006, fourteen tribal behavioral health grantees were enrolled as either a Community Mental Health Clinic and/or a substance abuse agency, and were enrolled to bill for Medicaid services. These were: Bristol Bay Area Health Corporation, Cook Inlet Tribal, Copper River Native Association, Eastern Aleutian Tribes, Fairbanks Native Association, Hoonah Indian Association, Kenaitze Indian Tribe, Ketchikan Indian Corporation, Maniilaq Association, Norton Sound Health Corporation, Southcentral Foundation, Southeast Regional Health Consortium, Tanana Chiefs Conference, and Yukon/Kuskokwim Health Corporation. Two other tribal entities, Aleutian Pribilof Island Association and Illiuliuk Family and Health, are enrolled, but have not yet billed.

**A3: Strategy - Strategy #1C: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder through the development of a comprehensive, integrated Behavioral Health Service System.**

**Target #1:** A fully integrated Behavioral Health Service system will occur over the next four years as evidenced by a 25% improvement in service outcomes and consumer satisfaction.

**Measure #1:** Treatment satisfaction data from Mental Health Statistics Improvement Program (MHSIP) Consumer Survey.

Consumer Survey.				
Percentage of MHSIP Respondents Satisfied with Services				
Table (1)				
Adult				
DOMAIN	FY2004	FY2005	FY2006	Percent increase between FY2004 and FY2006
Participation in Treatment Planning	67%	71%	70%	3%
Quality and Appropriateness	69%	77%	82%	18%
Outcomes	55%	61%	73%	33%
Access	68%	70%	74%	10%
General Satisfaction	77%	82%	82%	6%
FY2006-both Substance abuse and mental health consumers submitted surveys.				
Percentage increase column is calculated as follows: (FY2006-FY2004)/FY2004.				
Table (2)				
Family and Youth MHSIP				
DOMAIN	FY2005	FY2006	Percent increase (decrease) between FY2005 and FY2006	
Access to Service	71%	72%	3%	
Satisfaction with Services	68%	74%	9%	
Participation in Treatment	84%	81%	-4%	
Cultural Sensitivity	87%	86%	-2%	
Positive Outcomes of Services	58%	64%	11%	
FY2006-both Substance abuse and mental health consumers submitted surveys.				
Percentage increase column is calculated as follows: (FY2006-FY2005)/FY2005.				
Family and Youth surveys do not have sufficient response rates for FY2004 to use FY2004 as the base year.				
Table (3)				
Youth MHSIP				
DOMAIN	FY2005	FY2006	Percent increase (decrease) between FY2005 and FY2006	
Access to Service	70%	65%	-7%	
Satisfaction with Services	77%	74%	-4%	
Participation in Treatment	68%	67%	-1%	
Cultural Sensitivity	84%	86%	2%	
Positive Outcomes of Services	73%	64%	-12%	
FY2006-both Substance abuse and mental health consumers submitted surveys.				
Percentage increase column is calculated as follows: (FY2006-FY2005)/FY2005.				
Youth surveys do not have sufficient response rates for FY2004 to use FY2004 as the base year.				

**Analysis of results and challenges:** The Mental Health Statistics Improvement Project (MHSIP) Survey is one of several instruments used by the Division to measure clients' level of satisfaction with behavioral health services. The survey is mailed or given to consumers and returned by them directly to the Division of Behavioral Health for processing.

This Performance Improvement Process improves validity each year. Early in the implementation of the MHSIP, several factors greatly impacted the project: implementation was disrupted during the integration of the two Divisions (Mental Health and Alcoholism and Drug Abuse); and there was inconsistent incorporation into business practices of behavioral health service providers. As a result the validity of measures in FY2004 and FY2005 is questionable due to the poor response rates.

For FY2006, specific improvements instituted by the Division resulted in an increase of consumers participating in the survey, as well as an increase in the validity of findings. These included changes in the methodology of distribution and the expectation that behavioral health service providers participate in the survey. The Division also expanded the MHSIP survey to include substance abuse consumers.

For FY2007, the following changes have been implemented as part of the improvement process: the Division has (a) improved oversight of the implementation of the consumer survey; (b) developed a formal procedure to establish consistent implementation (timelines and methods) of the survey. It is anticipated that these changes in the consumer survey process will result in a continued improvement in the sampling size and validity of findings.

Clearly, adult clients of our programs are becoming more satisfied over the last several years, while children and their families are less satisfied with certain aspects of treatment. These are important pieces of information, which the Division is exploring in depth with the help of our providers and the consumers, in order to increase their levels of satisfaction and the positive outcomes of treatment. These MHSIP surveys are invaluable aids in knowing where to start asking these questions.

## Children's Services Results Delivery Unit

### Contribution to Department's Mission

The mission of the Office of Children's Services is to promote stronger families, safer children.

### Core Services

- Investigate reports of harm and ensure in-home services to children at-risk of harm.
- Develop permanency plans for children in out-of-home care.
- Facilitate treatment services, early intervention and family nutrition services.
- Prevent and remedy child abuse and neglect.

The Office of Children's Services (OCS) provides a range of services and support systems to prevent and remedy child abuse and neglect. These include child abuse and neglect prevention services, child protective services, foster care, residential care, family support and preservation services, adoption and guardianship, permanency planning, and health and nutrition services.

The Children's Services Management component delivers comprehensive program, managerial and financial support to the division's child protection services, family preservation services, and prevention services. This component has four primary units: the Deputy Commissioner's Office, the Family Services Unit, the Program Eligibility Unit and Tribal Relations Unit. This component also provides support services to the Online Resources for the Children of Alaska (ORCA) case management and financial/provider payment information management system. Other administrative functions provided for the OCS are located in Finance and Management Services under the department's Office of the Commissioner.

The Children's Services Training component provides education and training for OCS child protection social workers, licensing workers, supervisors, and managers to enhance their knowledge of child protection, abuse, and neglect. Required training increases employees' assessment skills in working with children and their families, and strengthens their ability to assess child safety and evaluate options to protect children when it has been determined that they would be unsafe remaining in their homes. Further, ongoing training allows workers to better ascertain the best interests of children as OCS pursues permanency for children who have been placed outside of their homes.

The Front Line Social Worker component delivers services to carry out the legal mandates of the department to prevent and remedy physical abuse, sexual abuse, neglect, mental injury, and the exploitation of children. For child protective services, primary activities include investigation of protective services reports; crisis intervention; assessment of the risk of future harm in the absence of intervention; family strength and needs assessment; and case planning. Additional functions include ongoing assessment toward achieving case plan goals, initiation of legal action to protect children, monitoring implementation of treatment plans, and the coordination services needed to reunify children with their families. Services of the Front Line Social Workers component also include arranging out-of-home care, when appropriate and necessary, in the least restrictive setting; and facilitating an alternative permanent home for children when their return to their home of origin is not possible.

The Family Preservation component awards grants statewide to non-profit agencies to provide services that keep children safe in their own homes; and to strengthen and support adoptive, foster, and extended families. Grantees provide family preservation services that help children at risk of foster care placement remain safely with their families, ensure after care once a child has been returned from foster care, and respite care to provide child care relief to families where a child is at risk of being abused or neglected.

Independent Living services support education, vocational training and life skills of youth in foster care as they enter early adulthood. These youths, 16 years and older, frequently lack the family or financial support and guidance needed to gain self-sufficiency as they enter adulthood. Services provided to help these youths gain self-sufficiency include life skills assessments; transition learning plans; exit plans that identify a youth's goals for education, employment, housing,

health care, mental health care, and family/community connections; financial assistance, and identification of additional resources the youth may require.

OCS's Foster Care Base Rate, Foster Care Augmented Rate and Foster Care Special Needs programs enable the state to find temporary homes for children who have been abused or neglected and cannot remain in their own homes. The OCS supports these foster care placements with services that both meet the needs of children in state custody and the department's statutory mandate to care for them. The Foster Care Base Rate program reimburses foster care providers for the basic ongoing costs of raising a child. The Augmented Foster Care Rate benefit covers extraordinary costs and higher levels of supervision not otherwise covered with base rate benefits. Foster Care Special Needs reimbursements are for pre-approved "one time" or "irregular" expenditures that are not covered through the Foster Care Base Rate program and that have been assessed on an as-needed basis.

OCS administers the Tribal Title IV-E Reimbursement Program. OCS, through agreements with Alaskan Tribes and Tribal Organizations, passes through approximately \$1.5 million of Title IV-E federal funds annually. In conjunction with OCS, Tribal staff provides child welfare services to Alaskan Native children in out of home placement and children at risk of out of home placement. Tribal organizations work closely with OCS to provide the federal government with the required, substantial documentation for IV-E determinations.

The Subsidized Adoption & Guardianship component furnishes permanent adoptive or guardianship homes and subsidies for children with special needs that are in custody of the state. These children would likely not be adopted without a subsidy because of their documented special needs. The program has been successful due to an increased emphasis on permanency planning and the commitment to move children from foster care to a placement, where permanency is assured, in as safe and as timely a manner as possible.

Residential Child Care facilities provide high quality, time-limited residential treatment services for abused, neglected, and delinquent children. These facilities deliver 24-hour care for children who are unable to remain in their own home or who need more structure and treatment than foster care provides. The OCS facilitates levels of residential treatment that include emergency stabilization and assessment, intensive residential treatment, residential diagnostic treatment and residential psychiatric treatment.

The Infant Learning Program ensures that young children who may have disabilities or developmental delays receive an evaluation to identify the potential need for early intervention services. Comprehensive, coordinated, home-based early intervention services include individualized family service plans outlining goals for the family and the child; child development information; home visits; physical, occupational, or speech therapy; specialized equipment; and/or referrals to other needed services.

The Early Childhood Comprehensive Systems Project is a federally funded project that facilitates planning and implementation of strategies in the areas of access to home medical care, family support and parent education, early care and education, and social-emotional development of young children.

The Strengthening Families Initiative (SFI) is a child abuse prevention effort supported by the Doris Duke Foundation that targets children in early care and education programs (child care centers and Headstart) between the ages of birth through five years. The SFI works to develop the protective skills of families through these settings and by offering supportive services to parents.

The Women, Infants, and Children (WIC) component includes family nutrition programs that seeks to help pregnant women, new mothers and young children eat well, learn about good nutrition, and stay healthy. Pregnant, postpartum, and breastfeeding women, infants and children receive nutrition education, referrals, and food warrants that will improve their health and nutritional status.

The Alaska Children's Trust program generates funds and commits resources to community-initiated projects that strengthen families and prevent child abuse and neglect. The Alaska Children's Trust awards grants from the net income of the Trust Fund to community-initiated projects on a competitive basis, monitors the approved grant projects for compliance and effectiveness, and submits to the Governor a report describing the services provided and the annual level of income and expense for the Alaska Children's Trust. The Trust solicits contributions through fund-raising activities, gifts and bequests and applies for private and federal grants consistent with the purpose of the trust, to increase the value of the fund.

The Child Protection Legal Services component provides a small portion of OCS costs for services purchased from the Department of Law to support legal requirements from the point when a child is taken into custody through mandatory, periodic court reviews, and to permanency if all efforts to reunite a child with his or her family are unsuccessful. This

particular component addresses the funding needed when a child cannot be reunified with his or her family and child's best interests are supported through adoption.

End Results	Strategies to Achieve Results
<b>A: To prevent children from abuse and neglect.</b>  <u>Target #1:</u> Increase the number of Early Intervention/Infant Learning Program screenings for children age 0 - 3 to meet federal requirements. <u>Measure #1:</u> The number of children age 0 - 3 screened annually.	<b>A1: Improve the referral process from Children's Protective Services to Early Intervention/Infant Learning Program services.</b>  <u>Target #1:</u> Increase the percentage of screenings provided to children ages 0-3 and attain federal compliance. <u>Measure #1:</u> Change in the percentage of completed referrals.  <b>A2: To reunify children in out-of-home placements with parents or caretakers as soon as it is possible.</b>  <u>Target #1:</u> Increase the rate of children reunified with their parents or caretakers within 12 months of removal. <u>Measure #1:</u> The percent of children reunified with parents or caretakers at the time of discharge from foster care in less than 12 months from the last removal.
End Results	Strategies to Achieve Results
<b>B: Safe and timely adoptions.</b>  <u>Target #1:</u> Increase the annual number of completed adoptions. <u>Measure #1:</u> Number of children placed in adoptive homes annually.	<b>B1: Implement resource family assessments.</b>  <u>Target #1:</u> Increase the number of resource family assessments completed annually. <u>Measure #1:</u> Number of resource family assessments completed annually.  <b>B2: Promote the use of adoption exchanges to recruit adoptive homes.</b>  <u>Target #1:</u> Increase recruitment of resource family homes. <u>Measure #1:</u> Number of resource family homes recruited annually.  <b>B3: Promote the adoption of older youth ages 12 - 18.</b>  <u>Target #1:</u> Increase the number of adoptions for youth age 12-18. <u>Measure #1:</u> The annual number of youth age 12-18 who are adopted.

### FY2008 Resources Allocated to Achieve Results

**FY2008 Results Delivery Unit Budget: \$154,869,300**

**Personnel:**

Full time	471
Part time	3
<b>Total</b>	<b>474</b>

## Performance Measure Detail

### A: Result - To prevent children from abuse and neglect.

**Target #1:** Increase the number of Early Intervention/Infant Learning Program screenings for children age 0 - 3 to meet federal requirements.

**Measure #1:** The number of children age 0 - 3 screened annually.

Year	No. of Screenings	Target
2003	113	800
2004	200	800
2005	225	800
2006	278	800

**Analysis of results and challenges:** The Early Intervention/Infant Learning Program (EI/ILP) goal is to have every child under the age of three with a substantiated protective services report screened and thus achieve federal compliance within three years. Currently EI/ILP screens only 40 percent of the required screenings under the Child Abuse Prevention and Treatment Act.

In 2003 US Congress passed the Strengthening Families Bill requiring all children birth through three years of age who have been abused or neglected to be referred to the Early Intervention/Infant Learning (EI/ILP) Program. By referring all 0-3 year old children who have a substantiated finding of abuse or neglect, the EI/ILP program can do an initial screening to identify speech and language delays, cognitive and motor delays and social and emotional delays and then connect families to any needed services. By linking families with services aimed at remedying identified needs of very young children, further abuse and neglect can be negated as associated risk factors are alleviated. While called prevention services, abuse or neglect has already occurred, and by providing this screening and subsequent services, the likelihood of repeat maltreatment is reduced.

The program, as the number of screenings increase, is improving strategies to meet the 100% goal. This task becomes more complex as increased attention related to the behavioral health needs of very young children increases. In the past, the need for these services and a child's eligibility for these services were based on education based domains of development. Strategies must be developed to assure referrals of children who are not yet of school age.

In 2005 EI/ILP discovered that 58% of infants and toddlers enrolled in EI/ILP services had delays in social and emotional development greater than 15%. 182 children (10%) had social and emotional delays greater than 50%. Currently programs do not have the capacity to provide adequate training and support to address the social and emotional needs of children currently enrolled in services, much less children with difficulties solely in social and emotional delays. Since 2003, Alaska has seen a 56% increase in the number of referrals from child protective services and expects this number to rise as child protection services and EI/ILP continue to improve communication and understanding of how best to provide supports to these children and families.

2006 data available for Fairbanks, Anchorage, and Mat-Su shows 71 referrals (from child protective services) to 7 enrollments (children receiving services) in Fairbanks; 128 referrals to 23 enrollments in Anchorage, and 11 referrals and no enrollments in Mat-Su.

## A1: Strategy - Improve the referral process from Children's Protective Services to Early Intervention/Infant Learning Program services.

**Target #1:** Increase the percentage of screenings provided to children ages 0-3 and attain federal compliance.

**Measure #1:** Change in the percentage of completed referrals.

### Percent of Early Intervention/Infant Learning Program Referrals

Fiscal Year	Percent Referred	Rate of Change	Target
FY 2003	14%	0	
FY 2004	25%	79%	
FY 2005	28%	12%	
FY 2006	35%	25%	100% or 800 Screenings

**Analysis of results and challenges:** The Early Intervention/Infant Learning Program (EI/ILP) goal is to attain federal compliance within the next three years -- meaning, 800 of 800 required screening for Alaska children ages 0-3 will be performed through the program. Currently, EI/ILP is screening approximately 40% of the required 800.

As shown above, the program has made steady progress for the past four years, but has work to do. Not only do the number of screenings need to go up, but the availability of services required as a result of each screening needs to increase. Currently, programs do not have the capacity to provide adequate training and support to address the social and emotional needs of these children.

The program, if funded, is planning to implement strategies to ensure access to adequate training and supports for the anticipated influx of children into the program.

## A2: Strategy - To reunify children in out-of-home placements with parents or caretakers as soon as it is possible.

**Target #1:** Increase the rate of children reunified with their parents or caretakers within 12 months of removal.

**Measure #1:** The percent of children reunified with parents or caretakers at the time of discharge from foster care in less than 12 months from the last removal.

### Rate of Reunification

Fiscal Year	Alaska Rate	National Standard
FFY 2001	62.4%	76.2%
FFY 2002	53.3%	76.2%
FFY 2003	54.7%	76.2%
FFY 2004	54.7%	76.2%
FFY 2005	53.3%****	76.2%

Data Source: Alaska's Online Resources for the Children of Alaska submission to the National Child Abuse and Neglect Data System.

FFY 2006 data will be available in November or December.

\*\*\*\*Introduction of the Online Resources for the Children of Alaska (ORCA) case management system. With the transition from the old case management system (PROBER) to the new ORCA system, data definitions, policies, and collection procedures have been changed to conform with federal requirements. While the underlying federal methodology for computing measures remains the same, measures computed from these two different systems should not be considered comparable.

**Analysis of results and challenges:** This measure represents the percentage of children that were returned to their parents or caretakers in less than twelve months from the time of the latest removal, known as the rate of reunification. While the OCS did achieve its goal as mandated by the Federal Performance Improvement Plan, there is much room for improvement in reunifying children with their families in a twelve month period.

With so much effort being placed on the new rollout of the safety assessment and emphasis on the front end of an OCS intervention to keep children safe, outcomes aimed at achieving permanency for children have

decreased by a small margin.

Efforts to improve this measure include collaboration with the Court Improvement Committee to highlight the need for Assistant Attorney Generals, Guardians ad Litem, Court Appointed Special Advocates, and judges to assist in helping the OCS to achieve permanency goals more timely.

By implementing the new safety model, permanency workers will be better equipped to determine whether children can be returned to their families sooner if the safety threats have been remedied and risk factors are all that remain. The premise behind the new safety model encourages workers to continue to assess through the life of the case whether children can be safely returned to their parents before all of the case plan requirements are met. If the reason OCS took children into custody was due to the child being unsafe, then the threshold for their return ought to be the same. On-going case plans can be monitored with children in their homes more easily with the family reunified than by requiring the family have achieved success by reducing all the risk factors as well.

Further, in 2004 the OCS released a new Request for Proposals (RFP) for Time Limited Family Reunification. The RFP was designed to help reduce the numbers of children experiencing repeat maltreatment and also to help increase the numbers of children being reunified with their families when they were in out-of-home care.

This model provided that the grantees use an assessment process to be completed with the family upon entry into the program and at different intervals in the life of the case, in order to assess the progress and safety factors as well as increase family functioning to ensure reunification. The RFP also provided for an in-home component to provide face-to-face contact with the family to gather assessment information and formulate a reunification plan. Reunification data is being captured from quarterly narrative reports and results should be available January 2007.

## B: Result - Safe and timely adoptions.

**Target #1:** Increase the annual number of completed adoptions.

**Measure #1:** Number of children placed in adoptive homes annually.

### Number of Children Adopted from State Custody by Federal Fiscal Year

Fiscal Year	Children Adopted	Annual Change
FFY 2001	278	75
FFY 2001	222	-56
FFY 2003	201	-21
FFY 2004	179	-22
FFY 2005	191	12
FFY 2006	203	12

Data Source: Online Resources for the Children of Alaska (ORCA)

FFY 2006 number of adoptions is untested. FFY 2006 final numbers will be available in November, 2006.

**Analysis of results and challenges:** Since the passage of the Adoption and Safe Families Act of 1997, Alaska has seen an increase in the number of finalized adoptions for children from the Office of Children's Services (OCS) custody. As of June 30, 2006, there were 1,989 children (approximately 87% federally funded and 13% state-funded) in the subsidized adoption program. Each year the OCS sees at least 150 children who are able to achieve permanency through adoption in the OCS system. The chart above shows the number of finalized adoptions as reported by Federal Fiscal Year. It is anticipated that over the next year the adoptions of children in the OCS custody will increase as OCS places continued emphasis on meeting the 15 out of 22 month timeframes outlined in the Adoption and Safe Families Act.

**B1: Strategy - Implement resource family assessments.**

**Target #1:** Increase the number of resource family assessments completed annually.

**Measure #1:** Number of resource family assessments completed annually.

**Annual Number of Resource Family Assessments Completed**

Fiscal Year	RFAs Completed	Change
FY 2005	15	0
FY 2006	27	12

Data Source: Office of Children's Services Adoption Subsidy Unit.

Prior year data is not available at this time. FY 2006 marks the first year this plan was administered by the Adoption Subsidy Unit.

**Analysis of results and challenges:** During the past fiscal year, the Office of Children's Services (OCS) has initiated an implementation plan for resource family assessments. Under previous OCS policy and practice, the process of licensing a resource family for foster care and the process for approving a family for an adoptive home were treated as separate, yet duplicative processes. Thus, families who initially were licensed for foster care (relative or non-relative) who were selected as the adoptive family for a specific child, were required to undergo a second assessment of their home and family before the adoption could be finalized.

The resource family assessment consolidates the licensing and approval processes into one streamlined process. Additionally, the resource family assessment provides a better assessment outcome so that matching of families with a child's needs is more appropriate. This matching allows for adoptive placements of children which are sensitive to the child's familial, cultural, and emotional ties at an earlier stage in the placement process. Thus, when the adoption plan is made for the child, the child does not need to make a placement change.

Phase I and Phase II of the implementation plan included an urban pilot in Anchorage and a rural pilot in several remote communities in Alaska. The results of these phases have indicated that improved placement decisions and outcomes are occurring through resource family assessments, with a greater emphasis on the assessment of risk and safety to children in the adoptive homes.

A total of 42 resource family assessments were completed during the Phase I and Phase II of the plan. The OCS anticipates a 100% increase in the number of completed resource family assessments during FY 2007 as compared to FY 2006, as the new resource family assessment procedures are incorporated into the OCS practice.

During the next fiscal year, the OCS will work to reach its goal of a 100% increase in the number of resource family assessments that are completed throughout Alaska to insure greater safety outcomes to adoptive children.

**B2: Strategy - Promote the use of adoption exchanges to recruit adoptive homes.**

**Target #1:** Increase recruitment of resource family homes.

**Measure #1:** Number of resource family homes recruited annually.

**Number of Resource Family Homes Recruited Annually**

Year	Initial Inquiries	# of Families Processed	Percent Processed
2006	102	63	62%

Data Source: Office of Children's Services Adoption Subsidy Unit.

Prior year data is not available at this time. FY 2006 marks the first year this plan was administered by the Adoption Subsidy Unit.

**Analysis of results and challenges:** The Office of Children's Services (OCS) participates in a state, regional, and national adoption exchange to assist with the identification of potential adoptive families for children in the OCS custody. The exchanges provide an opportunity to list the child and describe the family that would be best suited to meet the child's special needs in an effort to locate a family to adopt the child.

In Alaska, the use of the Alaska, Northwest and AdoptUsKids exchanges allows for the OCS to reach a broader network of waiting adoptive families throughout Alaska and the United States.

A total of 102 potential resource families made initial inquiries to the OCS for information on becoming a licensed resource family with the OCS. Of these 102 families, 63 families (60% of the initial inquiries) continued with the resource family orientation, training and licensing process with the OCS. OCS intends to increase the percentage of resource families who initiate the resource family licensing process to 70% of the total number of initial inquiries during the next fiscal year.

### **B3: Strategy - Promote the adoption of older youth ages 12 - 18.**

**Target #1:** Increase the number of adoptions for youth age 12-18.

**Measure #1:** The annual number of youth age 12-18 who are adopted.

#### **Number of Youth Age 12 - 18 Adopted by Federal Fiscal Year**

<b>Fiscal Year</b>	<b># Adopted</b>	<b>Change</b>
FFY 2005	36	0
FFY 2006	30	-6

*Data Source: Office of Children's Services Adoption Subsidy Unit.*

*FFY 2006 numbers are estimates. FFY tested numbers will be available November, 2006.*

**Analysis of results and challenges:** In the summer of 2006, the national focus for adoption was on the adoption of older youth from the child protection system. In Alaska, the focus on the increase of older youth adoptions (children 12-18 years of age) is a specific target for the next fiscal year. National research studies have indicated that children who age out of the foster care system have greater life challenges than children who leave the foster care system with connections to significant adults (parents, mentors, adoptive parents, guardians). For this reason, the OCS has focused on assisting older youth with developing and maintaining permanent connections in their lives, and for many of these youth, the connections will need to be legally permanent as well.

In FFY 2005, 36 children between the ages of 12-18 were adopted through the OCS foster care system. In FFY 2006, 30 children within the same age group were adopted from the OCS foster care system.

In FFY 2005, nearly 19% of the children who were adopted through the OCS were between the ages of 12-18; in FFY 2006 it is estimated that this percentage is closer to 15%. For the next fiscal year, the OCS is anticipating increasing the number of finalized adoptions for children 12-18 years of age by 25% from the FFY 2006 numbers.

## Health Care Services Results Delivery Unit

### Contribution to Department's Mission

Manage health care coverage for Alaskans in need.

### Core Services

- Provide access to appropriate health care services; and
- Assure access to a full range of health care service information to our customers.

The Division of Health Care Services (HCS) maintains the Medicaid core services by:

- Hospitals, physician services, pharmacy, dental services, transportation, physical, occupational, and speech therapy;
- Laboratory and x-ray;
- Durable medical equipment; and
- Hospice and home health care

Departmentwide, HCS administers the State Children's Health Insurance Program (SCHIP), the Medicaid Management Information System (MMIS), claims payments and accounting, third-party liability collections and recoveries, federal reporting activities, Medicaid Administrative Claiming, Medicaid Error Rate program, and the Chronic and Acute Medical Assistance program.

HCS also administers the following programs:

- Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Program. The EPSDT program assures that children enrolled in Medicaid receive preventative health care and additional diagnosis or treatment services as needed. Good quality preventative health care reduces subsequent medical care costs for these children. All Medicaid Services/EPSDT program activities are directed toward addressing federal EPSDT regulations and related federal initiatives. The program sends notice to parents or guardians of children due for well-child exams and immunizations; assists families in finding physicians, nurse practitioners, dentists and vision care providers, in their home community who accept new Medicaid patients; coordinates and funds transportation reimbursement to preventative health care appointments for children and pregnant women. Reimbursement assistance is available for health care appointments if the family would not otherwise be able to afford to attend the appointment.
- The Chronic and Acute Medical Assistance Program (CAMA). The CAMA program provides a limited package of health services to those individuals with chronic medical conditions who do not qualify for the Medicaid program. CAMA's limited benefits are only available to low-income persons with an immediate need for medical care who are unable to secure other private or public assistance.
- Tribal Health Agenda. The HCS is playing an integral role in the Tribal Health Agenda spearheaded by the Office of Program Review. Projects with tasks falling to HCS include development of policy that will enable tribes to bill for services under management contracts, review of new estate recovery policy, ensuring tribes that provide public health nursing services are included in the plan for Medicaid reimbursement, providing administrative, training and claims processing services for Tribal Medicaid Administrative Claims (Tribal MAC) agreements, providing support for data analysis, reporting, and training of tribes, and the development of "due" lists to support tribes who have continuing care provider agreements.

End Results	Strategies to Achieve Results
<b>A: Mitigate Health Care Services (HCS) service</b>	<b>A1: Increase Indian health services (IHS) participation</b>

<b>reductions by replacing general funds with alternate funds.</b>  <u>Target #1:</u> Reduce by 1% the GF expenses replacing them with alternate funds. <u>Measure #1:</u> Percent of general funds replaced with alternate funding.	<b>by 5% in expenditures.</b>  <u>Target #1:</u> Increase Indian health services (IHS) Medicaid participation by 5% in expenditures. <u>Measure #1:</u> Percentage of IHS direct service expenditures.  <b>A2: Expand fund recovery efforts.</b>  <u>Target #1:</u> Increase funds recovered by 2%. <u>Measure #1:</u> Change in amount of funds recovered.
<b>End Results</b>	<b>Strategies to Achieve Results</b>
<b>B: To provide affordable access to quality health care services to eligible Alaskans.</b>  <u>Target #1:</u> Increase by 2% the number of providers enrolled in Medicaid. <u>Measure #1:</u> Change in number of providers enrolled in Medicaid.	<b>B1: Improve time for claim payment.</b>  <u>Target #1:</u> Decrease by .5% the average time HCS takes to pay a claim. <u>Measure #1:</u> Change in the average time HCS takes to pay a claim.  <b>B2: Improve payment efficiency.</b>  <u>Target #1:</u> Increase percentage of claims paid by provider without error to promote timely and accurate payment. <u>Measure #1:</u> Change in percentage of adjudicated claims paid with no provider errors.

### FY2008 Resources Allocated to Achieve Results

**FY2008 Results Delivery Unit Budget: \$810,002,600**

**Personnel:**

Full time	56
Part time	1
<b>Total</b>	<b>57</b>

### Performance Measure Detail

#### A: Result - Mitigate Health Care Services (HCS) service reductions by replacing general funds with alternate funds.

**Target #1:** Reduce by 1% the GF expenses replacing them with alternate funds.

**Measure #1:** Percent of general funds replaced with alternate funding.

#### HCS Medicaid Actuals - Other Funds (in millions)

Year	% Federal	% General	% Other
1999	66.0%	34.7%	.8%
2000	65.3%	25.5%	9.2%
2001	66.4%	22.7%	10.9%
2002	66.6%	27.8%	6.1%
2003	67.5%	25.5%	7.1%
2004	71.1%	16.6%	12.4%
2005	71.5%	17.5%	11.0%

**Analysis of results and challenges:** Seek ways to maximize federal participation through Family Planning, Indian Health Service, Breast and Cervical Cancer, and Title XXI expenditures.

Charted numbers represent actual expenditures recorded in ABS as percentages. Note FY04 is the first year reported after the reorganization. Prior year actuals will include the complete Medicaid Program and therefore do not provide exact comparisons between fiscal years.

### **A1: Strategy - Increase Indian health services (IHS) participation by 5% in expenditures.**

**Target #1:** Increase Indian health services (IHS) Medicaid participation by 5% in expenditures.

**Measure #1:** Percentage of IHS direct service expenditures.

#### **Health Care Services IHS Participation (in millions)**

Year	Total Exp	IHS	% of Total	% Increase
1999	228.6	37.5	16%	
2000	268.4	49.4	18%	2%
2001	323.0	73.3	23%	5%
2002	385.9	89.3	23%	0%
2003	466.6	134.9	29%	6%
2004	503.6	154.5	31%	2%
2005	558.2	177.8	32%	1%
2006	316.5	98.4	31%	-45%
2007	119.5	33.6	28%	-1%

Source: Total Expenditures include all direct services claim payments in HCS Medicaid less drug rebates. IHS Direct services claim payments, including FairShare claims, are from MMIS-JUCE. The drug rebate offset is from AKSAS.

The FY2007 data is for the first quarter of FY2007 only.

DHSS, Finance and Management Services, Medicaid Budget Group using AKSAS and MMIS-JUCE data.

**Analysis of results and challenges:** Indian Health Service (IHS) expenditures decreased from first quarter FY06 to first quarter FY07 by \$12 million. The decrease is largely due to the termination of the FairShare Program, a federally-approved program wherein the state increased payments to a tribally-operated hospital. When the program ended, provider rates, as well as expenditures, decreased.

As the program readjusts itself to not including FairShare, evaluation of quarters and state fiscal years will yield more accurate comparisons.

IHS facilities are reimbursed for Medicaid services at a 100% federal participation whereas non IHS facility patient costs require a state match on expenditures.

#### **Background:**

Increased IHS billing capacity by tribal entities assists with revenue generation. This directly contributes to tribal entities being able to maintain and hire staff to serve recipients closer to home on a more consistent basis. It also decreases the number of American Indian/Alaska Native (AI/AN) beneficiaries going to non-tribal facilities. Tribal entities with 638 status receive 100% FMAP for service delivery to AI/AN beneficiaries, thus assisting the State with maximizing federal reimbursement through Centers for Medicare and Medicaid Services IHS. In addition, the Department of Health and Social Services (DHSS) completes periodic data matches between IHS and Management Information System (MMIS) to ensure that AI/AN beneficiaries are appropriately coded in the Eligibility Information System (EIS). This allows DHSS to capture 100% FMAP vs. the standard match for non-native.

Once an AI/AN beneficiary is connected to a tribal healthcare delivery system which is able to bill Medicaid, beneficiaries can access additional service areas if needed. Depending on the door the beneficiary enters, whether it's behavioral health, clinic, or dental for example, they become a part of the larger tribal healthcare delivery system of that region. The more revenue they generate per service category, the more consistent the long term system becomes.

**A2: Strategy - Expand fund recovery efforts.**

**Target #1:** Increase funds recovered by 2%.

**Measure #1:** Change in amount of funds recovered.

**Medicaid Recoveries: Drug Rebates & Third Party Liability Collections (in millions)**

Year	Drug Rebates	TPL	Total	% Change
2003	17.0	8.0	25.0	N/A
2004	19.4	10.1	29.5	18%
2005	30.2	8.7	38.9	24%
2006	27.5	9.4	36.9	-5%

**Analysis of results and challenges:** Health Care Services has seen an overall decline in its collections for drug rebates and third-party liability by 5% from FY05 to FY06. This is mainly attributable to a decline of drug rebate receipts that resulted from the implementation of the Medicare Part D program. More prescription drugs are covered by this federal program. Therefore, there are less state expenditures that qualify for drug rebate recoveries.

**B: Result - To provide affordable access to quality health care services to eligible Alaskans.**

**Target #1:** Increase by 2% the number of providers enrolled in Medicaid.

**Measure #1:** Change in number of providers enrolled in Medicaid.

**Number of Providers in Selected Provider Types Enrolled in Medicaid**

	FY2003	FY2004	FY2005	FY2006	FY2007 (YTD)
Physicians	6,440	7,076	6,486	6,406	6,002
Dentists	587	597	578	553	540
Pharmacies	359	356	287	224	205
Hospitals	734	841	739	751	634
Nursing Facilities	36	33	29	32	35
Sum	8,156	8,903	8,119	7,966	7,416

Source: DHSS, Finance & Mgmt Svcs, Medicaid Budget Group, MARS MR-0-06-T. The FY07 YTD information is for 1st quarter FY07.

**Analysis of results and challenges:** Provider enrollment is difficult to compare from any one period to another for a variety of reasons:

1. Provider enrollment and participation in the Alaska Medical Assistance programs is voluntary; providers may choose to end their enrollment at any time and do so for various reasons. A participating provider may enroll without rendering services, and a provider may be enrolled and stop billing for services without dis-enrolling.
2. The time limit for submission of claims is one year from the date services were rendered and some providers wait many months to bill, which may be a factor in participation and enrollment from year to year;
3. Out-of-state providers may be prompted to enroll when they see an Alaska Medicaid client or when they attempt to bill for the services rendered to our clients. These providers typically cease to participate and/or maintain their enrollment status once the few claims have been paid for these out-of-state health care encounters;
4. There are, at present, no strategies to increase provider enrollment or participation.

Timely payment is part of the strategy for retaining providers who participate in Medicaid. Provider retention is necessary if the department is to meet its goal of affordable access to health care. While it probably does not contribute to increased provider participation, failure to pay timely could negatively impact access to care if

dissatisfied providers stop seeing Medicaid patients.

### B1: Strategy - Improve time for claim payment.

**Target #1:** Decrease by .5% the average time HCS takes to pay a claim.

**Measure #1:** Change in the average time HCS takes to pay a claim.

**Analysis of results and challenges:** This measure is reported at the department level.

### B2: Strategy - Improve payment efficiency.

**Target #1:** Increase percentage of claims paid by provider without error to promote timely and accurate payment.

**Measure #1:** Change in percentage of adjudicated claims paid with no provider errors.

**Error Distribution Analysis – Percentage of Adjudicated Claims Paid with no Provider Errors <sup>1,2,3</sup>**

	FY02	FY03	FY04	FY05	FY06	FY07 (YTD)
<b>Total Claims Paid (fiscal year) <sup>2</sup></b>	<b>4,202,677</b>	<b>4,776,730</b>	<b>5,106,692</b>	<b>6,150,027</b>	<b>6,082,318</b>	<b>1,363,276</b>
<b>Percent Paid with No Errors (total claims)</b>	<b>74%</b>	<b>73%</b>	<b>76%</b>	<b>72%</b>	<b>74%</b>	<b>72%</b>
Hospitals	60%	65%	64%	65%	68%	74%
Physicians	67%	65%	64%	63%	66%	64%
Dentists	73%	74%	74%	73%	80%	75%
Nursing Home Facilities	65%	62%	62%	49%	54%	68%
Pharmacy	83%	80%	77%	77%	72%	64%
Mental Health	73%	76%	77%	74%	76%	78%
Transportation/Lodging	88%	86%	86%	75%	84%	86%
Home and Community Based Care	77%	78%	81%	87%	89%	88%
Vision	80%	77%	69%	76%	76%	81%
Psychiatric Hospital (Inpatient)	71%	42%	47%	55%	60%	65%
Clinics	71%	58%	49%	65%	67%	69%
Behavioral Rehabilitation Services	91%	86%	84%	87%	88%	92%
Chiropractic	60%	49%	51%	53%	54%	54%

*Notes*

<sup>1</sup> Between SFY02 and SFY03 reports were based on six months of data. Since SFY04 reports have been based on annual data.

<sup>2</sup> Total claims include all provider types.

<sup>3</sup> Source: MARS MR-0-11-T. FY07 YTD numbers are based on the 1<sup>st</sup> quarter of FY2007.

**Analysis of results and challenges:** Error distribution analysis is designed to capture the percentage of adjudicated claims paid with no provider errors. To ensure correct claim submission from providers, Health Care Services works with providers to resolve problem areas and to get claims paid. First Health, Medicaid's fiscal agent, provides training to providers on billing procedures, publishes billing manuals, and has a website for providers with information tailored to each provider type.

The sharpest decrease in percentage of adjudicated claims paid with no provider errors was between the first quarter of FY06 and FY07 is in Pharmacy. During FY06, the Department of Health and Social Services (HSS) had two major initiatives that impacted pharmacy: Pharmacy Cost Avoidance and Medicare Part D.

Prior to Pharmacy Cost Avoidance, HSS, as the State Medicaid Agency, paid the pharmacy claims for recipients who had insurance primary to Medicaid and then attempted to recover the costs from liable third parties. The Pharmacy Cost Avoidance initiative changed this practice and therefore the number of claims denied because of other insurance coverage is significant.

Additionally, Medicare Part D required HSS to deny pharmacy claims for Medicare-covered drugs for those recipients of both Medicaid and Medicare. Previously, Medicaid paid for this same population. This results in a significant denial of claims.

These major changes to the Pharmacy program were surely noteworthy enough to result in the decrease of claims paid, and as such, claims paid without error.

## Juvenile Justice Results Delivery Unit

### Contribution to Department's Mission

The Division of Juvenile Justice (DJJ) provides a comprehensive array of services for juveniles who have committed delinquent offenses, beginning at the point that law enforcement officers identify or apprehend juvenile offenders. The Division is responsible for conducting intake interviews for these offenders; providing short-term detention when necessary; diverting juveniles from the formal court process as appropriate; providing formal probation supervision; providing court ordered institutional treatment and community re-integration (aftercare). The Division's mission is to hold juvenile offenders accountable for their behavior, promote the safety and restoration of victims and communities, and assist offenders and their families in developing skills to prevent crime.

### Core Services

- ◆ Short-term Secure Detention
- ◆ Court ordered institutional treatment for juvenile offenders
- ◆ Intake investigation and outcome
- ◆ Probation Supervision and Monitoring
- ◆ Juvenile Offender Skill Development

The Division performs probation intake and supervision functions statewide and operates secure juvenile facilities in Anchorage (McLaughlin Youth Center), Palmer (Mat-Su Youth Facility), Kenai (Kenai Peninsula Youth Facility), Fairbanks (Fairbanks Youth Facility), Juneau (Johnson Youth Center), Bethel (Bethel Youth Facility), Nome (Nome Youth Facility) and Ketchikan (Ketchikan Regional Youth Facility). Probation offices are located in these same communities as well as Sitka, Prince of Wales, Kodiak, Palmer, Dillingham, Homer, Valdez, Barrow and Kotzebue.

End Results	Strategies to Achieve Results
<p><b>A: Outcome Statement #1 Improve the ability to hold juvenile offenders accountable for their behavior.</b></p> <p><u>Target #1:</u> Improve the ability to collect ordered restitution at the time of case closure to 100% of what was ordered.</p> <p><u>Measure #1:</u> Percentage of ordered restitution collected at the time of case closure compared to what was ordered.</p> <p><u>Target #2:</u> Improve the amount of community work service performed by juvenile offenders to 100% of what was ordered.</p> <p><u>Measure #2:</u> Percentage of community work service hours performed by juvenile offenders compared to what was ordered.</p>	<p><b>A1: Strategy 1a: Improve the timeliness of response to juvenile offenses.</b></p> <p><u>Target #1:</u> Seventy-five percent of juvenile referrals will receive an active response within 30 days from the date that the report is received from law enforcement (see note below).</p> <p><u>Measure #1:</u> The percent of delinquency referrals receiving an active response from juvenile probation within 30 days of the date the complete referral is received from law enforcement.</p> <p><b>A2: Strategy 1b: Improve the satisfaction of victims of juvenile crime.</b></p> <p><u>Target #1:</u> Develop a process to track victims' satisfaction with juvenile justice services.</p> <p><u>Measure #1:</u> Implementation of a process and/or protocol to record and assess victims' satisfaction with juvenile justice services.</p> <p><b>A3: Improve the Division's success in achieving compliance with audit guidelines for juvenile probation officers as specified in the DJJ field probation policy and procedure manual.</b></p>

**Target #1:** All field probation units will achieve an average of 95% compliance with all probation audit standards for each one-year period measured.

**Measure #1:** Average % of all probation audit standards met by probation officers over the course of the fiscal year.

### FY2008 Resources Allocated to Achieve Results

**FY2008 Results Delivery Unit Budget: \$48,638,400**

**Personnel:**

Full time	445
Part time	4
<b>Total</b>	<b>449</b>

### Performance Measure Detail

#### A: Result - Outcome Statement #1 Improve the ability to hold juvenile offenders accountable for their behavior.

**Target #1:** Improve the ability to collect ordered restitution at the time of case closure to 100% of what was ordered.

**Measure #1:** Percentage of ordered restitution collected at the time of case closure compared to what was ordered.

Year	Amt Ordered	Amt. Completed	% of Amt Ordered	Goal
2004	\$160,165.43	\$144,140.73	90.0%	100%
2005	\$70,911.20	\$69,343.23	97.8%	100%
2006	\$54,420.30	\$52,349.60	96.2%	100%

*Amount completed is amount at case closure.*

**Analysis of results and challenges:** This measure provides a gauge of the Division's effectiveness in assisting youths in their efforts to make reparations to those impacted by their criminal behavior. Juvenile probation officers are responsible for ordering and monitoring payments made outside the formal court system. Restitutions assigned through informal procedures are included in this measure, as are assignments of Permanent Fund Dividends made by juvenile probation officers. The amount of restitution reported as paid is that amount provided by the youth at the time of case closure. Restitutions tracked and gathered through youth courts and other community diversion programs are not included in this measure for FY 06. Since January 1, 2002, restitution payments by juveniles who are processed formally through the Alaska Court System have been tracked, collected, and reported by the Alaska Department of Law Collections & Support Unit and those restitution payments are also not included in this analysis.

The reduction in restitution ordered and paid in FY 06 through informal court processes may primarily be due to two factors: First, in the years since the Department of Law took over the restitution collections function, probation officers have gradually had fewer formal court-ordered restitutions to manage. Formal court-ordered restitutions are typically much larger than informally ordered restitutions that make up the final measure this year. Second, in previous years some probation offices counted restitutions that were ordered and collected from youth referred to youth courts. These restitutions are no longer counted in this measure since this would credit the Division with work that outside agencies are doing.

The Division this year integrated restitution tracking procedures into its Juvenile Offender Management Information System. It is believed that this change has resulted in more thorough and accurate reporting of restitution than in years past. Despite the overall decline in raw dollars ordered and collected, the percentage collected by DJJ staff remained high, indicating that DJJ staff continue to demonstrate a high degree of effectiveness in collecting on restitution payments they order.

Note: FY 06 data for this measure was retrieved from the JOMIS report, "Statewide Summary Restitution Report," on August 8, 2006.

**Target #2:** Improve the amount of community work service performed by juvenile offenders to 100% of what was ordered.

**Measure #2:** Percentage of community work service hours performed by juvenile offenders compared to what was ordered.

#### Community Work Service Hours

Fiscal Year	Hrs Ordered	Hours Completed	Percentage	Goal
FY 2004	24,379	23,720	96%	100%
FY 2005	34,167	30,642	90%	100%
FY 2006	33,214	27,429	82%	100%

*Hours completed are at closure of service record.*

**Analysis of results and challenges:** Like restitution, community work service is a way for juveniles to repair harm caused to those impacted by juvenile crime. This performance measure reports the percentage of community work service performed for cases in which community work service was ordered either through formal, court-ordered processes or informal processes directed by a juvenile probation officer. The record of community work service must have been closed in FY 06 to be included in this measure. Community work service ordered through youth courts or other alternative justice processes are not included.

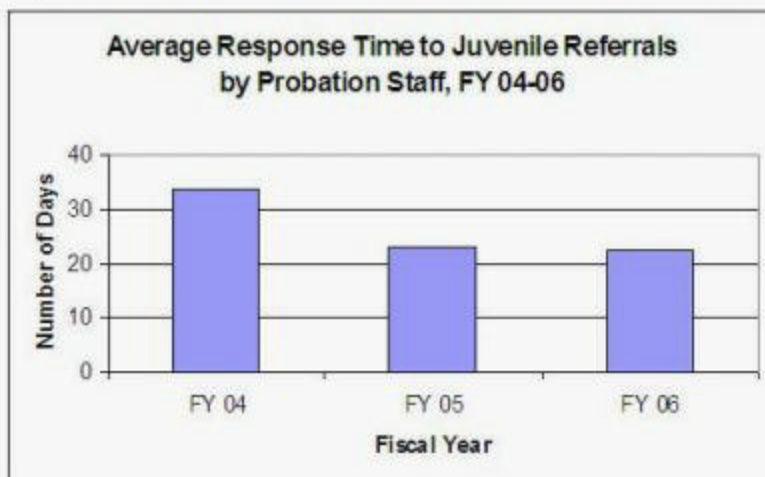
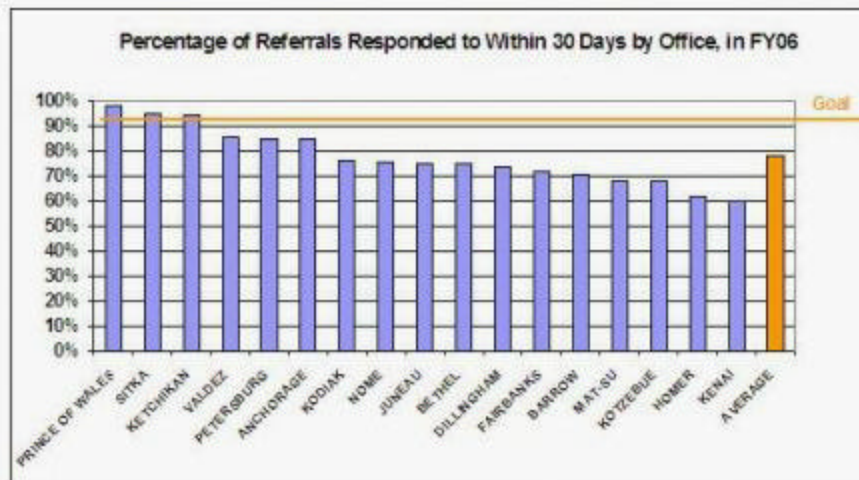
The percentage of community work service completed to what was ordered appears to have declined this year. This is likely due to changes in reporting of this measure. FY 06 marked the first full year that Community Work Service was tracked through the Division's Juvenile Offender Management Information System. In preparation for this change several inconsistencies and differences in the way offices tracked community work service were revealed. The Division recognized these concerns and has set explicit guidelines on how this information is to be entered in JOMIS. In the coming year we will monitor this information to make sure it is as accurate and complete as possible.

Note: FY 06 data for this measure was retrieved from the JOMIS report, "Statewide Summary Community Work Service Report," on August 15, 2006.

**A1: Strategy - Strategy 1a: Improve the timeliness of response to juvenile offenses.**

**Target #1:** Seventy-five percent of juvenile referrals will receive an active response within 30 days from the date that the report is received from law enforcement (see note below).

**Measure #1:** The percent of delinquency referrals receiving an active response from juvenile probation within 30 days of the date the complete referral is received from law enforcement.



**Analysis of results and challenges:** This measure enables the Division to monitor the percentage of cases that receive an active response within the target response time of 30 days. An "active response" is defined by the Division as one of three possible actions by staff to deal with the delinquency report (see note below). Research indicates that in order to be effective, responses to juvenile crime must be timely and appropriate to the level of the offense. The first chart above illustrates the percentage of referrals that received a response within 30 days of the date the referral was received by each office in Alaska. The statewide average percentage of referrals that received a response within 30 days was 78%, exceeding the goal of 75%. The second chart

illustrates the average number of days it took to actually respond to all referrals relative to previous years' data. The average response time in FY 06 was 22.4 days. FY 06 marked the second year that the Division was able to provide response time information through a streamlined procedure in the Juvenile Offender Management Information System (JOMIS).

Note: Delinquency reports, or "referrals" included in this analysis were those received in the fiscal year that resulted in one of the following actions: Referral Screening (review of the police report and either closing the referral or it being forwarded to a community accountability program, such as youth court), Petition Filed (resulting in an adjudication or dismissal by the court), or Intake Interview (which may result in referral being adjusted, dismissed, petitioned, or forwarded to a community accountability program).

\*Referral: A request for a Division of Juvenile Justice response service following the arrest of a juvenile or submission of a police investigation report alleging the commission of a crime or violation of a court order by a juvenile offender.

## **A2: Strategy - Strategy 1b: Improve the satisfaction of victims of juvenile crime.**

**Target #1:** Develop a process to track victims' satisfaction with juvenile justice services.

**Measure #1:** Implementation of a process and/or protocol to record and assess victims' satisfaction with juvenile justice services.

**Analysis of results and challenges:** The Division made significant progress this year in meeting this qualitative objective. The Division designed a victims' satisfaction survey to gauge victim satisfaction both soon after the juvenile delinquency episode and two years after their case has been processed. The Department's Finance and Management IT Section linked the survey to a website and database to enhance the ability for victims to report their experience with juvenile justice services. As of November 2006, the application needs to be tested by the Division and piloted in one of our probation offices so that statewide policies and procedures can be developed to guide its use.

## **A3: Strategy - Improve the Division's success in achieving compliance with audit guidelines for juvenile probation officers as specified in the DJJ field probation policy and procedure manual.**

**Target #1:** All field probation units will achieve an average of 95% compliance with all probation audit standards for each one-year period measured.

**Measure #1:** Average % of all probation audit standards met by probation officers over the course of the fiscal year.

### **Avg Audit Compliance Rate**

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total	Target	Variance
FY 2005	95.2	95.8	94.3	94.7	95%	95%	0
FY 2006	96.0	95.0	95.0	93.0	95%	95%	0

*In FY05, the division had 84 juvenile probation officer positions. Not all of those positions carry caseloads and at the time that the probation officers were audited, some of the positions were vacant. The total number of case carrying probation officers is approximately 75.*

**Analysis of results and challenges:** The data indicates that juvenile probation officers have been successful in meeting the goal of 95% audit compliance. This measure monitors the Division's success in achieving compliance with audit guidelines for juvenile probation officers as specified in the DJJ Field Probation Policy and Procedure Manual. Supervisory audits of each probation officer's caseload are conducted on a quarterly basis. These are used as a constructive means to assess an officer's performance in carrying out the required duties of the position and to ensure the delivery of appropriate services to each client. Data was collected for each quarter of the fiscal year as demonstrated above. In the coming year, the Division will be examining the format and method used to conduct audits of probation casework to attempt to make these audits an even more useful tool in determining the quality of juvenile probation officers' work.

## Public Assistance Results Delivery Unit

### Contribution to Department's Mission

The mission of the Division of Public Assistance is to promote self-sufficiency and provide basic living expenses to Alaskans in need.

To meet this mission, the Division administers programs that provide temporary economic support to needy families and individuals, financial assistance to the elderly, blind and disabled, benefits to supplement nutrition, medical benefits, and supportive services that enable and encourage welfare recipients to pursue economic independence and self-sufficiency.

### Core Services

- Provide temporary financial assistance to low-income Alaskan families with children who are capable of self-sufficiency to help them meet their basic needs.
- Provide employment assistance to low-income Alaskan families with children to help them become more self-sufficient.
- Provide financial assistance to low-income elderly, blind, or disabled Alaskans incapable of self-sufficiency to help them meet their basic needs.
- Provide food assistance to low-income Alaskans to decrease their incidence of food insecurity.
- Provide home heating assistance to low-income Alaskans to reduce their disproportionate burden of home heating costs.
- Provide child care subsidies to families who need child care to work or participate in approved work or training activities.
- License child care providers to increase the safety and quality of child care in Alaska.

The Public Assistance Results Delivery Unit (RDU) determines applicant eligibility and provides cash, food and heating assistance to needy Alaskans. The major programs are Alaska Temporary Assistance (ATAP), Food Stamps, Adult Public Assistance (APA), General Relief Assistance, Heating Assistance, SeniorCare, and Native Family Assistance. These programs provide an economic safety net for individuals and families that need help to support themselves and their children. Preventing dependency, promoting self-sufficiency and supporting clients toward obtaining employment and jobs capable of supporting a family are major responsibilities of the Division. The RDU also determines eligibility for Chronic and Acute Medical Assistance, Medicaid, and Denali KidCare. To qualify for public assistance, individuals must have income near or below poverty level and also meet a number of specific eligibility requirements which vary by program. The Division must meet payment accuracy requirements, work participation standards and timeliness guidelines or be subject to federal sanction or penalty.

End Results	Strategies to Achieve Results
<p><b>A: Low income families and individuals become economically self-sufficient.</b></p> <p><u>Target #1:</u> Increase self-sufficient individuals and families by 10%.</p> <p><u>Measure #1:</u> Rate of change in self-sufficient families.</p>	<p><b>A1: Increase the percentage of temporary assistance families who leave the program with earnings and do not return for 6 months.</b></p> <p><u>Target #1:</u> 90% temporary assistance families leave with earnings and do not return for 6 months.</p> <p><u>Measure #1:</u> Percentage of families that leave temporary assistance with earned income and do not return for 6 months.</p> <p><b>A2: Increase the percentage of temporary assistance families with earnings.</b></p> <p><u>Target #1:</u> 40% of temporary assistance families with earnings.</p> <p><u>Measure #1:</u> Percentage of temporary assistance families</p>

	<p>with earnings.</p> <p><b>A3: Increase the percentage of temporary assistance families meeting federal work participation rates.</b></p> <p><u>Target #1:</u> 50% of temporary assistance families meet federal work participation rates.  <u>Measure #1:</u> Percentage of temporary assistance families meeting federal work participation rates.</p> <p><b>A4: Improve timeliness of benefit delivery.</b></p> <p><u>Target #1:</u> 95% of food stamps expedited service applications meet federal time requirements.  <u>Measure #1:</u> Percentage of food stamps expedited service households that meet federal time requirements.</p> <p><u>Target #2:</u> 96% of new food stamps applications meet federal time requirements.  <u>Measure #2:</u> Percentage of new food stamps applications that meet federal time requirements.</p> <p><u>Target #3:</u> 99.5% of food stamps recertification applications meet federal time requirements.  <u>Measure #3:</u> Percentage of food stamps recertification applications that meet federal time requirements.</p> <p><u>Target #4:</u> 90% of temporary assistance applications meet time requirements.  <u>Measure #4:</u> Percentage of temporary assistance applications that meet time requirements.</p> <p><u>Target #5:</u> 90% of Medicaid applications meet federal time requirements.  <u>Measure #5:</u> Percentage of Medicaid applications that meet federal time requirements.</p> <p><b>A5: Improve accuracy of benefit delivery.</b></p> <p><u>Target #1:</u> 93% of food stamp benefits are accurate.  <u>Measure #1:</u> Percentage of accurate food stamp benefits.</p> <p><u>Target #2:</u> 95% of temporary assistance benefits are accurate.  <u>Measure #2:</u> Percentage of accurate temporary assistance benefits.</p> <p><u>Target #3:</u> 93% of Medicaid eligibility determinations are accurate.  <u>Measure #3:</u> Percentage of accurate Medicaid eligibility determinations.</p> <p><b>A6: Increase the percentage of subsidy children in licensed care.</b></p> <p><u>Target #1:</u> 76% of subsidy children are in licensed care.  <u>Measure #1:</u> Percentage of subsidy children in licensed care.</p>
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### FY2008 Resources Allocated to Achieve Results

**FY2008 Results Delivery Unit Budget: \$247,150,300**

**Personnel:**

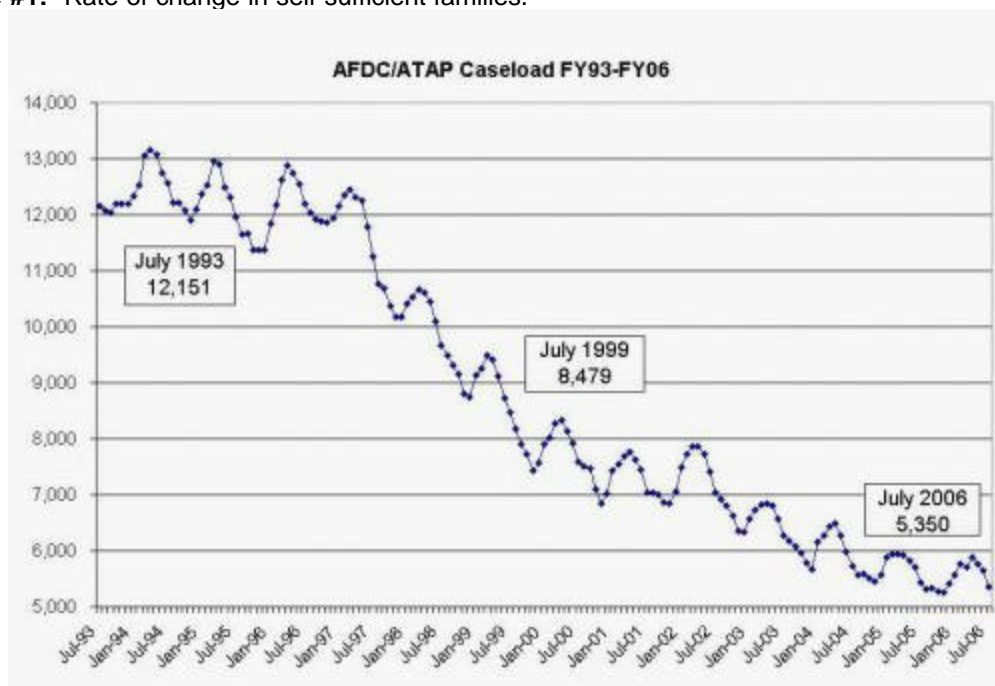
Full time	505
Part time	11
<b>Total</b>	<b>516</b>

### Performance Measure Detail

#### A: Result - Low income families and individuals become economically self-sufficient.

**Target #1:** Increase self-sufficient individuals and families by 10%.

**Measure #1:** Rate of change in self-sufficient families.



\*Table includes ATAP & Native Family Assistance Programs

#### Changes in Self Sufficiency

Fiscal Year	September	December	March	June	YTD Total
FY 2002	-16%	6%	4%	3%	-2%
FY 2003	-1%	-11%	-14%	-13%	-9%
FY 2004	-12%	-7%	-6%	-9%	-9%
FY 2005	-6%	-7%	-8%	-6%	-7%
FY 2006	-6%	-3%	-4%	-1%	-2%
FY 2007	-5%	0%	0%	0%	-5%

\*YTD Total Column represents the average annual monthly caseload rate change.

**Analysis of results and challenges:** As shown in the YTD Total column, FY2006 had a 2% decline in the number of families receiving Alaska Temporary Assistance Program benefits compared to FY2005. The other four monthly columns show a snapshot of caseload rate change compared to the previous year's month. (Note: The YTD Total column represents the average annual monthly caseload rate change.)

The goal is for clients to move off of Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the program. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of families becoming self-sufficient.

**A1: Strategy - Increase the percentage of temporary assistance families who leave the program with earnings and do not return for 6 months.**

**Target #1:** 90% temporary assistance families leave with earnings and do not return for 6 months.

**Measure #1:** Percentage of families that leave temporary assistance with earned income and do not return for 6 months.

**Percent of Temporary Assistance Families Who Leave the Program With Earnings and Do Not Return for 6 Months**

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	83%	83%	76%	81%	81%
2003	85%	87%	82%	82%	84%
2004	90%	85%	79%	80%	84%
2005	88%	85%	80%	82%	84%
2006	87%	87%	80%	84%	85%
2007	88%	0 0%	0 0%	0 0%	88%

**Analysis of results and challenges:** The goal is for clients to move off of Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the program. The measurement ties in job retention, since retaining employment is directly related to remaining off Temporary Assistance.

The Division provides childcare and supportive services to support employed families during the transition to self-sufficiency. Supportive services include case management support to continue coaching the employed client during this vulnerable period.

To calculate this measure, we divide the number of cases that closed with earnings 6 months ago by the number of cases that closed with earnings 6 months ago who are not in the current caseload. The calculation for the quarterly figures is a weighted average of the 3 months in the quarter. The YTD total is a weighted average of all the months so far in the year.

The FY07 target is 90%.

**A2: Strategy - Increase the percentage of temporary assistance families with earnings.**

**Target #1:** 40% of temporary assistance families with earnings.

**Measure #1:** Percentage of temporary assistance families with earnings.

**Percent of Temporary Assistance Adults With Earnings**

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	31%	28%	27%	31%	29%
2003	30%	28%	27%	32%	29%
2004	31%	29%	29%	35%	31%
2005	34%	31%	30%	35%	33%
2006	34%	32%	32%	36%	34%
2007	36%	0 0%	0 0%	0 0%	36%

**Analysis of results and challenges:** This is a measure of current Temporary Assistance recipients who have

earned income. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of recipients with earned income. The goal of the division's welfare-to-work effort is to move families off assistance and into a job that pays well enough for the family to be self-sufficient.

The calculation for the quarterly figures is a weighted average of the 3 months in the quarter. The YTD total is a weighted average of all the months so far in the year.

The FY07 target is 40%.

### **A3: Strategy - Increase the percentage of temporary assistance families meeting federal work participation rates.**

**Target #1:** 50% of temporary assistance families meet federal work participation rates.

**Measure #1:** Percentage of temporary assistance families meeting federal work participation rates.

#### **Percentage of temporary assistance families meeting federal work participation rates.**

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	38%	37%	36%	36%	36%
2003	32%	33%	33%	34%	34%
2004	36%	36%	36%	37%	37%
2005	39%	37%	39%	40%	40%
2006	42%	43%	44%	44%	44%
2007	47%	0 0%	0 0%	0 0%	47%

**Analysis of results and challenges:** Temporary Assistance (TA) is a work-focused program designed to help Alaskans plan for self-sufficiency and to make a successful transition from welfare to work. Federal law requires the state to meet work participation requirements. Failure to meet federal participation rates results in fiscal penalties.

The quarterly figures are YTD figures. The federal participation rate calculation is a running YTD figure.

The FY07 target is 50%.

As Alaska's TA caseload declines, a growing portion of the families require more intensive services just to meet minimal participation requirements. Enhancement of TA Work Services will serve to identify and address client challenges to participation.

In FY06, DPA began a family-centered services initiative to increase the self-sufficiency and self-responsibility of Alaska Temporary Assistance families with complex issues and multiple barriers to self-sufficiency.

Family Centered Services assesses the service needs of all members of a temporary assistance family, not just the adults who are required to participate in work activities. Program coordinators work with local Job Center partners and field staff from different programs, divisions, departments and community agencies to weave collective goals into integrated service plans to help families with complex challenges achieve a healthier self-sufficient family structure. This requires a much more collaborative and coordinated planning effort. Family Centered Services also uses a "customized employment" method of finding job opportunities for individuals participating in the project.

In FY06, DPA conducted Family Centered Services pilot projects in Fairbanks and the Mat-Su Valley. Results of the pilot projects show families participating have an increase in hours of participation in work and work-related activities, an increase in average monthly earnings, and an increase in the number of months of earnings.

**A4: Strategy - Improve timeliness of benefit delivery.**

**Target #1:** 95% of food stamps expedited service applications meet federal time requirements.

**Measure #1:** Percentage of food stamps expedited service households that meet federal time requirements.

**Percentage of food stamps expedited service households that meet federal time requirements**

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	95.4%	94.5%	93.4%	93.4%	93.4%
2003	94.0%	90.5%	90.8%	92.1%	92.1%
2004	93.2%	93.8%	94.5%	94.7%	94.7%
2005	90.9%	92.3%	92.7%	93.5%	93.5%
2006	95.0%	95.6%	96.0%	95.7%	95.7%
2007	96.5%	0 0%	0 0%	0 0%	96.5%

**Analysis of results and challenges:** Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The quarterly data are YTD figures. The FY07 target is 95%.

**Target #2:** 96% of new food stamps applications meet federal time requirements.

**Measure #2:** Percentage of new food stamps applications that meet federal time requirements.

**Percentage of new food stamps applications that meet federal time requirements**

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	93.0%	94.2%	94.3%	94.7%	94.7%
2003	95.9%	95.1%	95.1%	95.5%	95.5%
2004	96.2%	96.1%	96.3%	96.5%	96.5%
2005	95.2%	95.5%	95.7%	95.9%	95.9%
2006	95.4%	95.9%	96.1%	96.2%	96.2%
2007	97.2%	0 0%	0 0%	0 0%	97.2%

**Analysis of results and challenges:** Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY07 target is 96%.

**Target #3:** 99.5% of food stamps recertification applications meet federal time requirements.

**Measure #3:** Percentage of food stamps recertification applications that meet federal time requirements.

**Percentage of food stamps recertification applications that meet federal time requirements**

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	99.8%	99.8%	99.7%	99.6%	99.6%
2003	99.5%	99.5%	99.4%	99.4%	99.4%
2004	99.6%	99.6%	99.6%	99.6%	99.6%
2005	99.5%	99.5%	99.5%	99.6%	99.6%
2006	99.4%	99.5%	99.5%	99.5%	99.5%
2007	99.7%	0 0%	0 0%	0 0%	99.7%

**Analysis of results and challenges:** Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue

affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY07 target is 99.5%.

**Target #4:** 90% of temporary assistance applications meet time requirements.

**Measure #4:** Percentage of temporary assistance applications that meet time requirements.

**Percentage of Temporary Assistance applications that meet time requirements**

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	83%	86%	85%	86%	86%
2003	90%	88%	89%	90%	90%
2004	88%	88%	88%	88%	88%
2005	85%	84%	85%	85%	85%
2006	88%	86%	86%	87%	87%
2007	85%	0 0%	0 0%	0 0%	85%

**Analysis of results and challenges:** Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY07 target is 90%.

**Target #5:** 90% of Medicaid applications meet federal time requirements.

**Measure #5:** Percentage of Medicaid applications that meet federal time requirements.

**Percentage of Medicaid applications that meet federal time requirements**

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	89%	90%	89%	89%	89%
2003	91%	90%	90%	90%	90%
2004	88%	91%	91%	91%	91%
2005	92%	91%	91%	90%	90%
2006	89%	88%	89%	89%	89%
2007	88%	0 0%	0 0%	0 0%	88%

**Analysis of results and challenges:** Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY07 target is 90%.

**A5: Strategy - Improve accuracy of benefit delivery.**

**Target #1:** 93% of food stamp benefits are accurate.

**Measure #1:** Percentage of accurate food stamp benefits.

**Percentage of accurate food stamp benefits**

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	90.4%	92.4%	90.5%	89.2%	89.2%
2003	86.2%	84.7%	85.6%	86.4%	86.4%
2004	90.8%	94.2%	93.5%	93.3%	93.3%
2005	92.2%	93.2%	93.0%	93.8%	93.8%
2006	92.3%	93.5%	94.1%	0	94.1%

0%

**Analysis of results and challenges:** Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. The Quality Assessment Reviews evaluate payment accuracy using statistically valid sampling, case reviews, and home visits.

This is a cumulative measure based on the federal fiscal year (Oct-Sep) and it has about a two-month lag.

The FFY06 target is 93%.

**Target #2:** 95% of temporary assistance benefits are accurate.

**Measure #2:** Percentage of accurate temporary assistance benefits.

**Percentage of accurate temporary assistance benefits.**

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	88.2%	93.7%	93.6%	92.0%	92.0%
2003	94.4%	93.6%	94.5%	93.6%	93.6%
2004	96.7%	97.5%	98.2%	98.1%	98.1%
2005	98.5%	95.9%	95.7%	97.1%	97.1%
2006	98.1%	96.3%	97.7%	0 0%	97.7%

**Analysis of results and challenges:** Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. The Quality Assessment Reviews evaluate payment accuracy using statistically valid sampling, case reviews, and home visits.

This is a cumulative measure based on the federal fiscal year (Oct-Sep) and it has about a two-month lag.

The FFY06 target is 95%.

**Target #3:** 93% of Medicaid eligibility determinations are accurate.

**Measure #3:** Percentage of accurate Medicaid eligibility determinations.

**Percentage of accurate Medicaid eligibility determinations**

Year	YTD Total
2002	96%
2003	99%
2004	99%
2005	93%

**Analysis of results and challenges:** Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. Medicaid eligibility accuracy is compiled at the end of projects designed by the state and accepted by federal authorities.

The FFY06 target is 93%.

**A6: Strategy - Increase the percentage of subsidy children in licensed care.**

**Target #1:** 76% of subsidy children are in licensed care.

**Measure #1:** Percentage of subsidy children in licensed care.

**Percentage of subsidy children in licensed care**

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	0	60%	58%	64%	64%
2003	65%	66%	68%	75%	75%
2004	75%	76%	76%	76%	76%
2005	74%	81%	77%	80%	77%
2006	80%	84%	75%		

**Analysis of results and challenges:** The first available data regarding this measure is the second quarter in 2002.

There is a two month lag in the data.

The FY06 target is 76%.

## Public Health Results Delivery Unit

### Contribution to Department's Mission

The mission of the Division of Public Health is to protect and promote the health of Alaskans.

### Core Services

The Division of Public Health core services are:

- Prevention and control of epidemics and the spread of infectious disease;
- Prevention and control of injuries;
- Prevention and control of chronic disease and disability;
- Preparation for and response to disasters (natural disasters and terrorist attacks);
- Assurance of access to early preventive services and quality health care;
- Protection of the population against environmental hazards that impact human health; and
- Ensuring effective and efficient management and administration of public health programs and services.

These services are primarily population-based and focused on achieving and preserving the health and well being of entire communities and populations. Professional staff monitor and assess the health status of Alaskans through the collection and analysis of vital statistics, behavioral risk factor data, and data on disease and injury, including forensic data from postmortem examinations. The Division uses the data and other scientific information and expertise to develop sound policy and deliver disease control and health promotion services to protect and improve the health of Alaskans.

The Division helps achieve public health goals by assuring public health services are available through encouraging, supporting and sometimes requiring their development by others, and by providing services directly when unavailable from other providers. Staff also conduct disease surveillance and investigation and provide treatment consultation, case management and laboratory testing services to control outbreaks of communicable diseases and prevent epidemics. The Division promotes healthy behaviors by educating citizens and mobilizing and supporting community action to reduce health risks. Outreach activities are conducted to link high-risk and disadvantaged people to needed services, direct treatment and clinical preventative services.

End Results	Strategies to Achieve Results
<p><b>A: Outcome Statement: Healthy people in healthy communities</b></p> <p><u>Target #1:</u> Alaska's TB rate is less than 6.8/100,000 population. <u>Measure #1:</u> TB rate.</p> <p><u>Target #2:</u> Alaska's Chlamydia rate is less than 590/100,000 population. <u>Measure #2:</u> Chlamydia rate.</p> <p><u>Target #3:</u> Alaska's coronary heart disease death rate is less than 120/100,000 population. <u>Measure #3:</u> Heart disease death rate.</p> <p><u>Target #4:</u> Alaska's overall cancer death rate is less than 180/100,000 population. <u>Measure #4:</u> Cancer death rate.</p> <p><u>Target #5:</u> Reduce Alaska's unintentional injury death rate to 50/100,000 population.</p>	<p><b>A1: Reduce the risk of epidemics and the spread of infectious disease.</b></p> <p><u>Target #1:</u> 95% of persons with TB will complete adequate treatment within one year of beginning treatment. <u>Measure #1:</u> Percent of persons with TB completing treatment regimen.</p> <p><u>Target #2:</u> At least 98% of Chlamydia cases will be prescribed adequate treatment, as defined by CDC's STD Treatment Guidelines. <u>Measure #2:</u> Percent of persons with chlamydia prescribed adequate treatment regimen.</p> <p><b>A2: Reduce suffering, death and disability due to chronic disease.</b></p> <p><u>Target #1:</u> Less than 19% of high school youth in Alaska use tobacco products. <u>Measure #1:</u> Prevalence of tobacco use in Alaskan youth.</p>

Measure #5: Unintentional injury death rate.

**A3: Reduce suffering, death and disability due to injuries.**

Target #1: Increase seatbelt use to 80%.

Measure #1: Percent of properly restrained occupants in a motor vehicle.

**A4: Assure access to early preventative services and quality health care.**

Target #1: More than 60% of women of childbearing age will report knowledge that taking folic acid during pregnancy can reduce the risk of birth defects.

Measure #1: Percent of women reporting knowledge of folic acid benefits.

Target #2: 100% of Alaska's licensed and certified long-term care facilities are surveyed and recertified annually.

Measure #2: Percent of licensed and certified long-term care facilities surveyed and recertified annually.

**A5: Minimize loss of life and suffering from natural disasters and terrorist attack.**

Target #1: 25% of the Division of Public Health staff is trained in disaster response techniques and procedures.

Measure #1: Percent of DPH staff trained.

**A6: Reduce Alaskans' exposure to environmental human health hazards.**

Target #1: State lab has validated methods to test people for 100% of the important PCBs, pesticides and trace heavy metals.

Measure #1: Each new testing method validated as required by CLIA.

### FY2008 Resources Allocated to Achieve Results

**FY2008 Results Delivery Unit Budget: \$86,896,200**

**Personnel:**

Full time	495
Part time	21
<b>Total</b>	<b>516</b>

## Performance Measure Detail

### A: Result - Outcome Statement: Healthy people in healthy communities

**Target #1:** Alaska's TB rate is less than 6.8/100,000 population.

**Measure #1:** TB rate.

**Annual TB Rate per 100,000 population**

Year	US	Alaska
2000	5.8	17.2
2001	5.6 -3.45%	8.5 -50.58%
2002	5.2 -7.14%	7.6 -10.59%
2003	5.1 -1.92%	8.8 +15.79%
2004	4.9 -3.92%	6.6 -25.00%
2005	4.8 -2.04%	8.9 +34.85%

**Analysis of results and challenges:** Tuberculosis has been a longstanding problem in Alaska and was the cause of death for 46% of all Alaskans who died in 1946. Major efforts, utilizing 10% of the entire 1946 state budget and additional federal resources, led to one of the state's most visible public health successes - major reductions in TB. Tremendous inroads have been made to control TB in Alaska, although periodic outbreaks, usually in rural Alaska, have taxed both local and state resources. In 2000, Alaska had the highest rate of TB of any state in the country and additional funding was needed to effectively control two large outbreaks. In 2004, a multi-village outbreak involving Bethel and several surrounding Yukon-Kuskokwim villages again required additional public health resources and enhanced local response efforts. Unrelated to that outbreak, four Alaskans died with TB in 2004 because of delayed diagnosis and treatment - three Alaska Native elders and a Laotian. On an on-going basis, even when there are no outbreaks, significant resources are needed to do the TB case finding, diagnostic tests and treatment follow-up necessary to keep this disease in check. In addition, for every person with TB, there are, on average, 16 people who were exposed and must also be found, evaluated, and often treated as well.

Despite the outbreak and deaths in 2004, Alaska had the lowest rate of TB ever recorded for the state. Alaska's population is small, so only a few cases can dramatically affect the statewide rate. For instance, the latest increase is a difference of just 16 cases – 43 in 2004 up to 59 in 2005. There was no specific outbreak that caused the 2005 increase, and it is important to note that the overall trend of TB incidence in Alaska continues to head downward.

However, because of latent TB infection among residents and Alaska's location as a global crossroads that attracts travelers, seasonal workers and new families, infection rates are expected to fluctuate and remain higher than the national average over the next generation. TB remains deeply entrenched in many regions of Alaska, while the homeless and foreign-born residents also suffer disproportionate rates of the disease.

To control the on-going challenge of TB, the Department needs a strong and multi-pronged public health team of professionals knowledgeable about current issues of TB control. Such expertise will always be necessary if the disease once called the "Scourge of Alaska" is to be controlled and eventually eliminated.

**Target #2:** Alaska's Chlamydia rate is less than 590/100,000 population.

**Measure #2:** Chlamydia rate.

**Chlamydia rate per 100,000 of population**

Year	Alaska	U.S.
1999	303	247
2000	410 +35.31%	251 +1.62%
2001	433 +5.61%	275 +9.56%
2002	593 +36.95%	289 +5.09%
2003	602 +1.52%	304 +5.19%
2004	604 +0.33%	320 +5.26%
2005	656.5 +8.69%	N/A

**Analysis of results and challenges:** Sexually transmitted infections remain major causes of illness in Alaska and may have serious health consequences. New infectious agents and diseases are being detected, and some diseases once under control have reemerged in recent years. In addition, antimicrobial resistance is evolving over time.

Many challenges remain. Targeted screening with more sensitive technologies, as well as increased disease investigation activities, have actually increased the total numbers of STD cases diagnosed. These activities effectively identify infected individuals with no symptoms and also allow identification and treatment of other exposed individuals before they develop symptoms or further transmit infection. Case numbers are expected to decline over time as these activities reduce the reservoir of infected individuals in the population.

Identification, notification, testing, and treatment of sexual contacts of STD cases are time-tested, effective strategies for the HIV/STD Program. In combination with targeted screening and treatment activities, these strategies are effective in containing chlamydia and many other sexually transmitted infections. The basic public health infrastructure for STD and HIV prevention and control is in place: public health laboratory services, public health capacity for patient and partner follow up, and capacity to provide epidemiologic support, data analysis, and data dissemination. Some elements of this infrastructure (e.g., partner notification services) currently need additional resources to strengthen and expand them to respond to increased needs; all elements require on-going maintenance and monitoring. Most of the financial resources currently identified to support STD prevention and control are federal, and funding has declined over time.

**Target #3:** Alaska's coronary heart disease death rate is less than 120/100,000 population.

**Measure #3:** Heart disease death rate.

**Coronary Heart disease death rate per 100,000**

Year	Alaska	US
1999	131.5	194.6
2000	137.7 +4.71%	186.7 -4.06%
2001	136.6 -0.80%	177.8 -4.77%
2002	118 -13.62%	170.9 -3.88%
2003	126.6 +7.29%	162.9 -4.68%
2004	94.9 -25.04%	150.5 -7.61%
2005	87.1 -8.22%	N/A

**Analysis of results and challenges:** Nationally, heart disease is the leading cause of death for all Americans. An estimated 12 million men and women have a history of coronary heart disease (the most common form of heart disease). In 1998, almost 460,000 people died of coronary heart disease (44% of these deaths were from heart attacks). Although death rates from coronary heart disease have declined since the late 1960s, the decline has slowed since 1990. The lifetime risk for developing this disease is very high in the United States. One of every two males and one of every three females aged 40 years and under will develop it sometime in their life.

Heart disease is the second leading cause of death in Alaska, and cerebrovascular disease (most commonly referred to as stroke) is the fourth leading cause of death in Alaska. Over the past decade, Alaska's age-adjusted mortality rate for coronary heart disease has continued to decline. This mirrors the national trend, although Alaska's rates fall consistently below those found in the U.S. overall. In 2002, 2004 and 2005, Alaska's coronary heart disease death rates fell below the Healthy Alaskans 2010 target, which is 120 deaths per 100,000 population.

While there are no hard data to explain the downward trend in coronary heart disease deaths, it is likely that improvements in medical care are prolonging life, even for patients with advanced heart disease. In addition, Alaskans diagnosed with heart disease sometimes move south to receive treatment; their eventual deaths are not recorded in this state.

**Target #4:** Alaska's overall cancer death rate is less than 180/100,000 population.

**Measure #4:** Cancer death rate.

**Cancer death rate per 100,000 of population**

Year	Alaska	US
1999	192.5	200.8
2000	209.6 +8.88%	199.6 -0.60%
2001	192.2 -8.30%	196.0 -1.80%
2002	189.4 -1.46%	193.5 -1.28%
2003	187.7 -0.90%	190.1 -1.76%
2004	183.9 -2.02%	184.6 -2.89%
2005	160.5 -12.72%	N/A

**Analysis of results and challenges:** Cancer is not a single disease, but rather a constellation of more than 100 related diseases. Everyone is at risk of cancer. In the United States, half of all men and one-third of all women will develop cancer during their lifetimes. Of the approximately 491,000 Americans who are diagnosed with cancer in any given year, four of every ten are expected to still be living five years after diagnosis. Cancer was rarely seen in Alaska during the 1950s, but in the 1990s cancer was the leading cause of death in Alaska.

Over the past 10 years, the overall cancer death rate in Alaska has declined, closely mirroring the decline seen in U.S. cancer mortality rates for the same period. The Healthy Alaskans 2010 target is 162 deaths per 100,000 population.

The leading types of cancer deaths in Alaska for women are, in order, lung, breast and colorectal cancers. For men, the leading types of cancer deaths are lung, colorectal and prostate.

**Target #5:** Reduce Alaska's unintentional injury death rate to 50/100,000 population.

**Measure #5:** Unintentional injury death rate.

**Unintentional injury death rate per 100,000 population**

Year	Alaska	US
1999	57.5	35.3
2000	63.9 +11.13%	34.9 -1.13%
2001	61.1 -4.38%	35.6 +2.01%
2002	59.2 -3.11%	36.9 +3.65%
2003	55.1 -6.93%	37.2 +0.81%
2004	54.9 -0.36%	36.6 -1.61%
2005	46.3 -15.66%	N/A

**Analysis of results and challenges:** Injuries are a significant public health and social services problem because of the prevalence of injuries, the toll of injuries on the young, and the high cost in terms of resources and suffering. Alaska has one of the highest injury rates in the nation. Both the intrinsic hazards of the Alaska environment and low rates of protective behavior contribute to injuries. Unintentional injuries were the third leading cause of death in Alaska in 1998. Unlike heart disease and cancer, which are the leading causes of death among the elderly, injuries are the leading cause of death in children and young adults.

The Division of Public Health along with its many partners continues to see the benefits of actions related to injury control and prevention. The Safe Boating Act and Kids Don't Float are only two examples of the activities that contribute to success in reaching and maintaining this target. The Division of Public Health's Injury Control Program will continue to partner with others and to use surveillance and prevention strategies to understand and target interventions.

**A1: Strategy - Reduce the risk of epidemics and the spread of infectious disease.**

**Target #1:** 95% of persons with TB will complete adequate treatment within one year of beginning treatment.

**Measure #1:** Percent of persons with TB completing treatment regimen.

**% of Persons with TB Completing Treatment Regimen**

Year	Annual
2002	95%
2003	93%
2004	86%
2005	59%*

\*TB treatment requires 6-9 months for completion. 2005 completion data are still being collected.

**Analysis of results and challenges:** The highest priority for TB control is to ensure that persons with the disease are diagnosed early and complete curative therapy. If treatment is not continued for a sufficient length of time, people with TB become ill and contagious again, sometimes with resistant TB the second time. Completion of therapy is essential to prevent transmission of the disease as well as to prevent the development of drug-resistant TB. The measurement of completion of therapy is an important indicator of the effectiveness of community TB control efforts.

**Target #2:** At least 98% of Chlamydia cases will be prescribed adequate treatment, as defined by CDC's STD Treatment Guidelines.

**Measure #2:** Percent of persons with chlamydia prescribed adequate treatment regimen.

**% of Chlamydia cases prescribed adequate treatment**

Year	Annual
2003	99.5%
2004	99.6%
2005	99.8%

**Analysis of results and challenges:** HIV/STD Program staff follow-up to assure treatment for all reported cases. Given such follow-up, very few cases are identified that are not treated consistent with the current national recommendations. Challenges include maintaining resources necessary to assure identified infections are appropriately treated, and carefully evaluating recommended treatment modalities to assure they are efficacious.

In calendar year 2005, 99.8% of the 4,357 reported cases of chlamydia infection were prescribed adequate treatment.

**A2: Strategy - Reduce suffering, death and disability due to chronic disease.**

**Target #1:** Less than 19% of high school youth in Alaska use tobacco products.

**Measure #1:** Prevalence of tobacco use in Alaskan youth.

**Prevalence of tobacco use in Alaska youth in past 30 days (per YRBS survey)**

Year	Alaska	US
1999		34.8
2001		28.5
		-18.10%
2003	19.3	21.9
		-23.16%

**Analysis of results and challenges:** Many Alaskans are currently at risk for developing cardiovascular disease due to such risk factors as smoking, overweight, poor diet, sedentary lifestyle, high blood pressure and cholesterol, and lack of preventive health screening. Smokers' risk of heart attack is more than twice that of nonsmokers. Chronic exposure to environmental tobacco smoke (second-hand smoke) also increases the risk of heart disease. Cigarette smoking is also an important risk factor for stroke.

Tobacco is a leading cause of preventable disease and death in the United States. The majority of Alaska smokers (almost 80%) began smoking between the ages of 10 and 20 years. Alaskans have been working to decrease youth tobacco use through increasing the tax on tobacco products, education of young people, enforcement of laws restricting sales to minors, and a statewide ban on self-service tobacco displays.

In 1995, 37% of Alaska youth reported smoking at least once in the last thirty days, compared with 19.3% in 2003. Data is available from the Youth Risk Behavior Survey when enough Alaska schools participate to give results that can be generalized to the high school population as a whole in the State. This was the case in 1995 and 2003. Surveys occurred in other years, however, they did not have enough participants to provide statewide results, including 2005. It is the goal of the Division of Public Health to continue to work with schools to collect a representative sample every other year.

Healthy Alaskans 2010 target is 19.0%.

**A3: Strategy - Reduce suffering, death and disability due to injuries.**

**Target #1:** Increase seatbelt use to 80%.

**Measure #1:** Percent of properly restrained occupants in a motor vehicle.

**Seat Belt Use by Drivers and Passengers**

Year	Alaska	US
1999	60.6	67.0
2000	61.3 +1.16%	71.0 +5.97%
2001	62.6 +2.12%	73.0 +2.82%
2002	65.8 +5.11%	73.0 0%
2003	78.9 +19.91%	79.0 +8.22%
2004	77.0 -2.41%	80.0 +1.27%
2005	78.4%	82%

**Analysis of results and challenges:** Injuries are a significant public health and social services problem because of their prevalence, the toll of injuries on the young and the high cost in terms of resources and suffering. Alaska has one of the highest injury rates in the nation. Both the intrinsic hazards of the Alaska environment and low rates of protective behavior contribute to injuries and death. Unintentional injuries are the third leading cause of death in Alaska.

Studies have shown that a primary seatbelt enforcement law that allows police to stop and cite motorists for failing to comply with the seatbelt law is most effective in reaching a higher level of seatbelt use compliance. The Alaska Legislature began its 2006 session by finally passing such a law. Meanwhile, efforts are on-going to increase seatbelt use through public information messages and other targeted activities.

The Healthy Alaskans 2010 target is 80 percent seatbelt usage.

**A4: Strategy - Assure access to early preventative services and quality health care.**

**Target #1:** More than 60% of women of childbearing age will report knowledge that taking folic acid during pregnancy can reduce the risk of birth defects.

**Measure #1:** Percent of women reporting knowledge of folic acid benefits.

**Knowledge of Folic Acid Benefits, Alaska**

Year	Overall	Alaska Native
1999	77.5	60.9
2000	80.8 +4.26%	62.3 +2.30%
2001	80.5 -0.37%	63.1 +1.28%
2002	80.8 +0.37%	63.5 +0.63%
2003	82.0 +1.49%	65.3 +2.83%

**Analysis of results and challenges:** Folic acid knowledge among Alaskan mothers is increasing. The proportion of women who indicated that they knew about the benefits of folic acid increased from 63.0% in 1996 to 82.0% in 2003.

The proportion of Alaska Native mothers who knew about the benefits of folic acid increased by 65% between 1996 and 2003. While the prevalence of folic acid knowledge among Alaska Native mothers of newborns was still substantially lower than overall levels, the gap in knowledge between Alaska Natives and Alaskan mothers

overall appears to be closing.

Starting in 2000, the proportion of mothers of newborns who are knowledgeable about the benefits of folic acid appears to have plateaued around 80%.

For women of childbearing age, increasing folic acid use by taking multivitamins before and during pregnancy can reduce the risk of neural tube birth defects. Numerous public education campaigns have sought to increase women's knowledge of the benefits of folic acid supplementation and educate them especially about the importance of the timing (pre-pregnancy supplementation is ideal). Efforts should focus on increasing the overall knowledge prevalence to 90% and minimize racial disparities.

**Target #2:** 100% of Alaska's licensed and certified long-term care facilities are surveyed and recertified annually.

**Measure #2:** Percent of licensed and certified long-term care facilities surveyed and recertified annually.

**% of licensed and certified long-term care facilities surveyed and re-certified annually**

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	42.86	21.43	21.43	14.29	100%
2003	21.43	42.86	14.29	21.43	100%
2004	35.71	21.43	21.43	14.29	92.86%
2005	26.67	33.33	13.33	20	93.33%
2006	20	26.7	40	20	106.7%

**Analysis of results and challenges:** The annual required schedule for nursing home surveys is driven in large part by federal certification requirements. Surveys are to be completed within a 9- to 15-month period. Certification and Licensing (C & L) may not appear to meet the licensing and certification goal within a given calendar or fiscal year, or sometimes it may be over 100%. However, C & L will consistently meet federal and state certification and licensing survey requirements. The Section's scheduling is affected by significant increases or decreases in complaints or reports of harm, and by significant changes in staff resources.

**A5: Strategy - Minimize loss of life and suffering from natural disasters and terrorist attack.**

**Target #1:** 25% of the Division of Public Health staff is trained in disaster response techniques and procedures.

**Measure #1:** Percent of DPH staff trained.

**# and % of Division of Public Health staff trained in disaster preparedness**

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2005			70	103	27%
FY 2006				144*	28%

\*144 Division of Public Health staff received disaster preparedness training in FY2006. Quarterly numbers are not available.

**Analysis of results and challenges:** Disaster response training for Division of Public Health (DPH) staff is enabling DPH to carry out its role in disaster response operations. Training is the critical link between planning and action and permits all concerned to maintain a common knowledge base.

The FY06 percentage above reflects the following: 520 total DPH positions, with 144 receiving disaster preparedness training - for a total of 28 percent trained. This slightly exceeds the Division goal of 25 percent. However, when only filled positions are considered (415 at the end of FY06), then the total of DPH-trained staff increases to 35 percent.

**A6: Strategy - Reduce Alaskans' exposure to environmental human health hazards.**

**Target #1:** State lab has validated methods to test people for 100% of the important PCBs, pesticides and trace heavy metals.

**Measure #1:** Each new testing method validated as required by CLIA.

**% testing methods for PCBs, pesticides and heavy metals validated by CLIA**

Year	Target	Actual
2006	75%	50%
2005	75%	50%
2004	10%	10%

**Analysis of results and challenges:** PCBs, pesticides and trace heavy metals can affect human health, especially that of the developing fetus. The chief concern in Alaska centers on the presence of contaminants in traditional foods. Generally these foods are very nutritious and offer a number of health benefits. This testing measures human exposure to contaminants and verifies the safety of traditional foods. For years, the federal government, through the Clinical Laboratory Improvement Amendments (CLIA) process, has certified the state lab. However, no chemical testing (for PCBs, etc.) was offered at the lab until 2004. Now the lab conducts CLIA-certified testing of inorganics, and testing for Persistent Organic Pollutants (POPs) is expected to begin in FY07.

## Senior and Disabilities Services Results Delivery Unit

### Contribution to Department's Mission

The mission of the Division of Senior and Disabilities Services is to promote the independence of Alaska's Seniors and people with physical and developmental disabilities.

### Core Services

- 1) Institutional and community-based services for older Alaskans and persons with disabilities.
- 2) Protection of vulnerable adults.

End Results	Strategies to Achieve Results
<b>A: Improve and enhance the quality of life for seniors and persons with disabilities through cost-effective delivery of services.</b>  <u>Target #1:</u> Reduce % of Medicaid recipient not receiving medical assessments to less than 5%. <u>Measure #1:</u> % of clients not receiving medical review.	<b>A1: Arrange for beneficiaries to receive a medical assessment to determine what services they are eligible for and at what level. Through prior authorization process, ensure beneficiaries only receive the services they are eligible to receive.</b>
End Results	Strategies to Achieve Results
<b>B: Promote improved service and compliance with federal/state regulations through provider agencies.</b>	<b>B1: Develop, implement and maintain an on-going system of review and improvement through Technical Assistance Plans for each grantee and provider agency. Provide 8 care coordination training sessions each year in Alaskan communities.</b>  <u>Target #1:</u> Reduce incidence and severity of errors resulting in audit findings by 10% by providing adequate training to provider agencies. <u>Measure #1:</u> Show an overall reduction in error rates from audit findings for current rate by 10%.
End Results	Strategies to Achieve Results
<b>C: Ensure manageable caseload number in Adult Protective Services and Quality Assurance Units to provide timely investigations.</b>  <u>Target #1:</u> Reduce APS staff assigned case loads by 10% and length of time a case is "open" by 10%. <u>Measure #1:</u> Average length of time required to close a case in days per worker.	

## FY2008 Resources Allocated to Achieve Results

FY2008 Results Delivery Unit Budget: \$373,221,000

**Personnel:**

Full time	93
Part time	2
<b>Total</b>	<b>95</b>

## Performance Measure Detail

**A: Result - Improve and enhance the quality of life for seniors and persons with disabilities through cost-effective delivery of services.****Target #1:** Reduce % of Medicaid recipient not receiving medical assessments to less than 5%.**Measure #1:** % of clients not receiving medical review.**DSDS Outstanding Medicaid Assessments (FY05-FY07)**

Fiscal Year	% Not Reviewed
FY 2005	30.9%
FY 2006	23.18%
FY 2007	0.00%

*This chart shows the percentage of DSDS Medicaid recipients that have not been assessed using a standardized assessment tool by an objective assessor from FY05-FY07 (projected).*

**Analysis of results and challenges:** The Personal Care Attendant Program is the only Medicaid program that has not required a state-approved medical assessment to receive services. Implementation of new regulations in early 2006 began requiring a state-approved medical assessment and prior authorization of Medicaid benefits ensuring that beneficiaries are only receiving the services they are eligible to receive. This table shows the percentage of outstanding Medicaid assessments from 2005-2007 (projected.) DSDS anticipates that all back-logged Medicaid Waiver assessments will be caught up by the end of FY2007.

**A1: Strategy - Arrange for beneficiaries to receive a medical assessment to determine what services they are eligible for and at what level. Through prior authorization process, ensure beneficiaries only receive the services they are eligible to receive.****B: Result - Promote improved service and compliance with federal/state regulations through provider agencies.**

**B1: Strategy - Develop, implement and maintain an on-going system of review and improvement through Technical Assistance Plans for each grantee and provider agency. Provide 8 care coordination training sessions each year in Alaskan communities.**

**Target #1:** Reduce incidence and severity of errors resulting in audit findings by 10% by providing adequate training to provider agencies.

**Measure #1:** Show an overall reduction in error rates from audit findings for current rate by 10%.

**Myers and Stauffer Error Rates (FY05-FY06)**

Summary of Meyers and Stauffers FY05 & FY06	Error Rate Fiscal Year 2005	Error Rate Fiscal Year 2006
Skilled Nursing	8.55%	0.00%
Home & Community Services	18.53%	6.33%
Assisted Living	26.28%	16.14%
Care Coordination	16.23%	1.61%
Personal Care	14.42%	4.75%
<b>DSDS Total</b>	<b>15.83%</b>	<b>6.43%</b>

This chart shows FY05 and FY06 initial payment error rates as determined by Myers and Stauffer, an independent auditing firm hired by the Department of Health and Social Services.

**Analysis of results and challenges:** The chart shows DSDS Medicaid programs that have been audited by Myers & Stauffer and the percentage of audit exceptions that have been assigned to each program. These audit numbers are preliminary until the provider agencies have had a chance to respond, so these numbers should decrease as providers respond to the findings. However, it does show that significant improvement was made in the error rates across DSDS programs from FY05 to FY06.

## C: Result - Ensure manageable caseload number in Adult Protective Services and Quality Assurance Units to provide timely investigations.

**Target #1:** Reduce APS staff assigned case loads by 10% and length of time a case is "open" by 10%.

**Measure #1:** Average length of time required to close a case in days per worker.



\*FY2007 - Projected Caseload

### Annual Adult Protective Services Caseloads

Fiscal Year	Total Investigations	# Full-time Workers	Annual Cases per Worker
FY 2004	1173	7	168
FY 2005	1497 +27.62%	7 0%	214 +27.38%
FY 2006	1666 +11.29%	7 0%	240 +12.15%
FY 2007	1737 +4.26%	9 +28.57%	193 -19.58%

\* FY07 reflects estimates only.

**Analysis of results and challenges:** The annual caseload for an Adult Protective Services (APS) case worker has been steadily on the rise since FY2004. From FY04 to FY05, the average caseload increased by more than 27%. From FY05 to FY06, the average caseload increased again, this time by more than 12%. Based on this unexpected growth, the Division requested and was given permission to establish two (2) new case worker positions in the FY07 budget. Because of these new positions, the Division anticipates being better able to keep up with estimated increases to reports of harm, abuse and neglect of vulnerable adults. The average length of time it took to investigate a new case was approximately 6 days in FY06, when there were only 7 case workers. Now DSDS has 9 case workers to perform investigations and the current trend shows there may be a decrease to the growth in the number of reported cases by more than 8%. If this trend continues, average caseload per case worker will be approximately 193 cases per year in FY07. With new staff numbers, it takes approximately 2.6 days to investigate a new report of harm. This represents a decrease in the number of days it takes to investigate a report of harm by approximately 56.7%! The division anticipates that if 2 new positions are approved in the FY08 budget that the number of days it takes to investigate a new case could drop to less than two (2) days!

## Departmental Support Services Results Delivery Unit

### Contribution to Department's Mission

To provide quality administrative services that support the Department's programs.

### Core Services

- Promote cost containment. Maximize revenue.
- Provide Divisions with necessary information to improve compliance with federal and state laws/policies to ensure our fiduciary responsibilities are met.
- Improve DHSS staff knowledge and skills and maintain high morale to continually improve performance and services for Alaskans.
- Provide efficient centralized administrative support to 9 DHSS Divisions; maintain offices in Juneau and Anchorage.

The components of the Department Support Services RDU contribute towards the Core Services as follows:

- The Commissioner's Office component funds upper-level management and policy development for the entire department.
- The Office of Program Review component ensures that DHSS programs accomplish their goals, and helps Divisions find ways to refinance programs to ensure that, to the maximum extent possible, services continue to be provided to those most in need.
- The Office of Faith Based and Community Initiatives component provides guidance, direction, support and seeks financing to support faith-based and community initiative programs and services.
- The Office of Rate Review component establishes efficiency and consistency in rate-setting functions throughout the Department. Rate setting will be centralized for all services including Medicaid facilities, foster care and child care facilities.
- The Administrative Support Services component funds financial, budget, procurement, grant and professional service contract administration, information services and audit services as well as human resource liaison functions.
- The Hearings and Appeals component focus is on Health Care Facility appeals of Medicaid payment rates and audit findings.
- The Facilities Management component includes the management of the department's capital programs.
- The Health Planning and Infrastructure component focus is on community health needs assessments, health indicators tracking, data analyses and reports, health plan development, community health grants, health service design and documentation of program effectiveness through health care data.
- The Facilities Maintenance component, Pioneer Homes Facilities Maintenance, and HSS State Facilities Rent components record dollars spent to operate state facilities. These units collect costs for facilities operations, maintenance and repair, renewal and replacement as defined in AS 35 Public Buildings, Works, and Improvements and pay rent fees for Rent Project.
- The Information Technology (IT) component focus is to improve the efficiency and effectiveness of IT services and develop a more capable IT organization for the department.

End Results	Strategies to Achieve Results
<b>A: Facilitate the Department's Mission Through Superior (effective &amp; efficient) Delivery of Administrative Services.</b>  <u>Target #1:</u> DHSS Administration as a percentage of Department overhead should be below 2%. <u>Measure #1:</u> Percentage administration personal services is to total department budget.	<b>A1: Implement Business Process Reviews.</b>  <b>A2: Implement Department's Administrative Training Plan Curriculum.</b>

<u>Target #2:</u> Process capital grant payments within 5 days. <u>Measure #2:</u> Number of days to process a grant payment after receiving reports.	
End Results	Strategies to Achieve Results
<b>B: Improve Customer Service</b>  <u>Target #1:</u> Increase by 2% the percentage of customers that report that Finance and Management Services is meeting their needs. <u>Measure #1:</u> Percentage of survey respondents to each Finance and Management Section (FMS) that report FMS is meeting their needs.	<b>B1: Establish and Maintain Guaranteed Standards.</b>  <b>B2: Continue Customer Service Plan.</b>
End Results	Strategies to Achieve Results
<b>C: Improve overall management of DHSS budget processes.</b>  <u>Target #1:</u> Increase percentage of federal collections by 1% a year. <u>Measure #1:</u> Percentage of federal collections.  <u>Target #2:</u> Improve Legislative understanding of the DHSS budget. <u>Measure #2:</u> Respond to 80% of legislative inquiries by Budget Unit within 5 working days.	<b>C1: Increase federal collections.</b>  <b>C2: Improve Legislative understanding of the budget.</b>
End Results	Strategies to Achieve Results
<b>D: Facilitate the Department's day-to-day operations through effective and efficient delivery of services.</b>  <u>Target #1:</u> Reduce the length of time and number of days to respond and close out service calls. <u>Measure #1:</u> Number of days to close out service calls.  <u>Target #2:</u> 85% of construction projects completed on time and within budget. <u>Measure #2:</u> Percentage of construction projects done on-time and within budget.	<b>D1: Improve IT service call turn around time by implementing and maintaining software tracking system.</b>

### FY2008 Resources Allocated to Achieve Results

**FY2008 Results Delivery Unit Budget: \$63,278,500**

**Personnel:**

Full time	380
Part time	1
<b>Total</b>	<b>381</b>

## Performance Measure Detail

### A: Result - Facilitate the Department's Mission Through Superior (effective & efficient) Delivery of Administrative Services.

**Target #1:** DHSS Administration as a percentage of Department overhead should be below 2%.

**Measure #1:** Percentage administration personal services is to total department budget.

#### Percentage administration personal services is to total department budget

Year	YTD Total
2003	3.6%
2004	4.3%
2005	1.3%
2006	1.4%

**Analysis of results and challenges:** It is the goal of Department of Health and Social Services to keep administrative costs as low as practicable.

Department administration personnel services equal all of Department Support Services RDU. This number is compared to the total DHSS Expenditures.

**Target #2:** Process capital grant payments within 5 days.

**Measure #2:** Number of days to process a grant payment after receiving reports.

#### Number of days to process a grant payment after receiving reports.

Fiscal Year	YTD Total
FY 2003	5.60 days
FY 2004	4.89 days
FY 2005	3.11 days
FY 2006	3.36 days

**Analysis of results and challenges:** For FY06, there were 93 capital grant payments, all processing within 15 days.

### A1: Strategy - Implement Business Process Reviews.

### A2: Strategy - Implement Department's Administrative Training Plan Curriculum.

**B: Result - Improve Customer Service**

**Target #1:** Increase by 2% the percentage of customers that report that Finance and Management Services is meeting their needs.

**Measure #1:** Percentage of survey respondents to each Finance and Management Section (FMS) that report FMS is meeting their needs.

Finance and Management Service Functions - % Agree or Strongly Agree meeting service needs:					
Service	2003	2004	% Change	2005	% Change
Grants & Contracts	68.2%	64.9%	-5.1%	65.4%	0.8%
Procurement	70.6%	66.5%	-6.2%	71.3%	6.7%
Facilities Management	75.7%	76.1%	0.5%	76.5%	0.5%
Audit	74.0%	81.9%	9.6%	78.3%	-4.6%
Finance	63.1%	64.8%	2.6%	62.7%	-3.3%
Information Services	72.4%	71.4%	-1.4%	70.9%	-0.7%
Budget	66.8%	67.4%	0.9%	70.8%	4.8%
Assistant Commissioner's Office	74.3%	71.9%	-3.3%	76.7%	6.3%
Human Resources*	60.0%	57.0%	-5.3%	65.2%	12.6%
* No longer in DHSS but still tracking.					

**Analysis of results and challenges:** An internal customer survey on Finance and Management Services performance is conducted annually. The 2006 survey has not been completed.

Survey results show that 64.0% of survey respondents ranked overall FMS service performance to be above average (6) or higher on a scale of 1-10.

Individual core services are surveyed, however only the overall results are shown in the above table. Combined average of respondents agreeing or highly agreeing that core services are meeting their needs is 71.5% for 2005, an increase of 0.9% over 2004. This is compared to a 0% increase from FY03 to FY04.

The long-term target is to increase the % of respondents showing that FMS is meeting their needs by 5% from the base year of 2003.

Although the department saw increased results in some service areas from FY04 to FY05, the overall % did not meet expectations. Finance and Management Services conducted Business Process Reviews in FY05 on all services provided and is in the process of implementing recommendations from those reviews. We anticipate that these improvement areas, i.e. finance, budget and revenue, will help increase respondent ratings in FY06.

**B1: Strategy - Establish and Maintain Guaranteed Standards.****B2: Strategy - Continue Customer Service Plan.**

**C: Result - Improve overall management of DHSS budget processes.**

**Target #1:** Increase percentage of federal collections by 1% a year.

**Measure #1:** Percentage of federal collections.

**Percent of DHSS Budget that is Federal**

Year	YTD Total
2002	51.4%
2003	53.6%
2004	54.5%
2005	54.8%
2006	54.5%

**Analysis of results and challenges:** It is important to note that because the Department of Health and Social Services has a large number of federal programs, the more federal revenue that we receive, the less general funds that the department has to use.

**Target #2:** Improve Legislative understanding of the DHSS budget.

**Measure #2:** Respond to 80% of legislative inquiries by Budget Unit within 5 working days.

**% of Responses for Legislative Requests made within 5 working days**

Fiscal Year	YTD Total
FY 2002	83%
FY 2003	83%
FY 2004	78%
FY 2005	79%
FY 2006	80%

**Analysis of results and challenges:** It is important that policy makers working on key budget issues get their information timely in order to make decisions regarding the DHSS budget.

The Budget Section received approximately 147 requests in CY 2003, 186 in CY 2004 and 236 in FY 2005.

In previous years (2002 to 2004) the data was reported on calendar year but starting in (2005) the data is collected by fiscal year. The average processing time for FY2006 is 3.52 days and 80% were completed within 5 working days.

**C1: Strategy - Increase federal collections.****C2: Strategy - Improve Legislative understanding of the budget.****D: Result - Facilitate the Department's day-to-day operations through effective and efficient delivery of services.**

**Target #1:** Reduce the length of time and number of days to respond and close out service calls.

**Measure #1:** Number of days to close out service calls.

**Average Number of Days to Complete Service**

Fiscal Year	YTD Total
FY 2005	8.2 days
FY 2006	4.9 days

*FY 2005 data represents only 3 quarters. This measure began at the start of the 2nd quarter.*

**Analysis of results and challenges:** This measure was developed at the start of 2nd quarter in FY05. It is important to note that FY05 was the first year of integrated service delivery and not all divisions were in the system. In 2006, all divisions were in the system; the data was consistent and showed a 50% improvement in turnaround time.

There are a total of 15 categories of work/service performed that have been used to calculate the above averages. (In the 2nd quarter there were only 13 categories tracked.)

Examples of categories are, but not limited to:

Setting up Accounts; Application work; password setup; procurement of equipment; relocation of equipment; security; software; web; hardware or file maintenance, etc.

**Target #2:** 85% of construction projects completed on time and within budget.

**Measure #2:** Percentage of construction projects done on-time and within budget.

**Percent of Completed Construction Projects On Time and Within Budget.**

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2006	100%	100%	56%	85%	85.25%

**Analysis of results and challenges:** The Department began tracking construction projects in FY 06. Since that time, 85.25% of construction projects have been completed on time and within budget.

**D1: Strategy - Improve IT service call turn around time by implementing and maintaining software tracking system.**